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:	MooreHaven Centre (Tipperary) DAC
Name of provider:	MooreHaven Centre (Tipperary) Designated Activity Company
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	14 August 2025
Centre ID:	OSV-0003723
Fieldwork ID:	MON-0047992

About the designated centre

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

The designated centre is located in a large rural town. It provides residential care for 19 adults over the age of 18 years. The centre provides supports to full-time residents both male and female with an intellectual disability and autism. The centre is comprised of four dwellings in close proximity to local amenities and facilities within the town. The service operates on a 24 hour, seven days a week basis with staff present by day and night. One house was a two storey dwelling comprised of a ground floor with a living room, a kitchen / utility room, a bedroom for staff and a bedroom en-suite. The first floor contained a bedroom en-suite, 3 bedrooms and a bathroom. One house was a two storey dwelling comprised of a ground floor with a living room, a kitchen / utility room and a bedroom. The first floor contained a bedroom en-suite, 3 bedrooms and a bathroom. One of these bedrooms was the staff sleepover room. One house was a bungalow comprised of a ground floor with a sun room, a living room, a kitchen, a bedroom for staff and a bedroom en-suite, 4 bedrooms and a bathroom. One house was a bungalow comprised of a ground floor with a sun room, a living room, a kitchen / dining room and utility room, a bedroom for staff, 5 bedrooms and 3 bathrooms. All dwellings had front and rear gardens. The staff team was supervised by a person in charge who was a social care leader. The staff supporting residents include a person in charge, team leaders, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

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
Thursday 14 August 2025	09:15hrs to 17:30hrs	Sarah Mockler	Lead
Friday 15 August 2025	08:30hrs to 13:30hrs	Sarah Mockler	Lead
Thursday 14 August 2025	09:15hrs to 17:30hrs	Marie Byrne	Support
Friday 15 August 2025	08:30hrs to 13:30hrs	Marie Byrne	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed by two inspectors of social services over two days. The purpose of the inspection was to provide assurance that safe and good quality care was being provided to residents in this centre.

The findings of the this inspection were poor which was having a negative impact on aspects of residents' quality of care. The designated centre was not meeting the assessed needs of all residents. Inspectors found that improvement was required in the overall governance of the centre, the premises, staffing supports, risk management, individualised assessment and personal planning and safeguarding and protection. These areas will be discussed further in the body of the report.

The designated centre provides a community residential service for up to 19 adults with an intellectual disability. The centre comprises of four premises in a large town in County Tipperary. Two of these premises are next door to each other, and the other two are a short drive away.

There were 18 residents living in the centre and the inspectors had an opportunity to meet 16 of them over the course of the inspection. One resident was in hospital at the time of the inspection and another resident was on holidays with their family.

Over the course of the two days, inspectors visited each of the premises that made up the designated centre. They had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre including residents, the person in charge, the Chief Executive Officer, two team leaders and four staff members. Inspectors spent time over the course of the inspection engaging with residents and observing aspects of their day including them engaging in and choosing activities, taking part in the upkeep of their home, preparing and enjoying meals and snacks and spending time with their peers and staff.

Documentation was also reviewed throughout the inspection about how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre.

On the first day of the inspection, inspectors visited two houses. On arrival they found that residents were in the process of getting ready for their day. Some residents were getting ready for day services and others were having breakfast while waiting for staff to providing their wraparound service to arrive. They spoke about their plans for the day and the rest of the week which included visiting family members, going to a knitting club, going to bingo, going shopping, going out for meals and snacks, doing arts and crafts, and attending birthday parties. In one of the houses residents spoke about how much they had enjoyed a music and dancing event they had attended the night before. They also spoke about recent holidays

they had enjoyed with each other and with their families.

The inspectors completed a walk around of both premises. One of the premises required a number of maintenance works due to the age of the premises and general wear and tear occurring. All aspects of the home required painting. In addition, the cleanliness of this home was not of a high standard and required more attention to detail. Although the second home was in better condition and was clean and well presented, some minor works were also identified in this home.

On the second day of the inspection, an inspector visited the other two houses in the centre while the other inspector revisited one of the other houses. They both met and spoke with residents and staff and observed aspects of residents' day. Residents spoke about their plans for the day, things they liked to do, their achievements and their goals. Two residents spoke about a recent foreign holiday they had enjoyed and another resident spoke about a recent city break abroad which they had enjoyed. One resident spoke about how much they enjoyed working in a local business one day a week. Overall, both of these homes were well maintained and kept at a good standard.

For the most part a number of residents told inspectors they were happy and felt safe living in their homes. However, inspectors were told and they reviewed documentation, to indicate that one resident's care and support needs could not be met in the centre. This resident had a number of changing needs over recent years and due to a decline in the resident's mobility their needs were not being met. This was having a significant impact on their quality of life.

In addition, inspectors spoke with one resident who indicated they were experiencing difficulties sharing their home with their peers. These areas will be discussed further in the body of the report.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, inspectors found the systems for oversight and management of the centre were not effective. This was having a negative impact in relation to residents' lived experience within the home. Areas such as meeting residents' assessed needs, staffing supports, the maintenance and upkeep of the premises, risk management and safeguarding required improvements to ensure they met the minimum standard of compliance with the Regulations.

The local management team consisted of the person in charge and four team leaders. Three weeks prior to this inspection, the provider notified the Chief Inspector of Social Services that the previous person in charge had departed. They

provider had recruited a new person in charge who was due to commence in the centre in October 2025. As an interim measure they appointed a person in charge who previously held that role in this designated centre. This person was also identified as person in charge of another designated centre operated by the provider.

The interim person in charge facilitated the inspection and were found to be knowledgeable in relation to residents' care and support and demonstrated an awareness of some of the areas where improvements were required across the centre. However, they had a large managerial remit which consisted of oversight and management of five separate premises and the care and support of 19 residents.

The person in charge reported to and integrated services manager and Chief Executive Officer.

Regulation 15: Staffing

Inspectors found that the provider was not clearly demonstrating that the centre was resourced to meet residents' care and support needs. The inspectors found that there were insufficient staff within one of the homes to directly meet the assessed needs of the residents.

As part of the previous compliance plan response, the provider was required to complete an assessment of needs for each resident which would inform the staffing needs in each of the homes. None of these assessments were on the residents' files. The person in charge was able to provide one assessment in relation to one resident with specific changing needs. The assessment identified the need for a waking night staff to mitigate risks around fire evacuation and attending to personal care needs. At the time of inspection there was no waking night in place in the centre. There was no effective system in place to ensure the resident's personal care needs were met during the night. Staff reported that they would mainly attend to the personal care needs of the resident in the morning as they were on a sleep over shift. This meant timely care was not always provided to the resident in line with their needs.

The inspectors reviewed a four week period of rosters for this home. It was found that there was one staff member who completed a sleepover shift and a second staff member was rostered for one hour in the morning and for set times in the afternoon and evening. Overall, there was a consistent staff team in place that were working very diligently to support the residents . However, the staffing arrangements were not meeting the assessed needs of the residents. In daily notes it was documented that due to the protracted time it was taking to complete transfers with one resident, the resident was asked to lie back in bed as staff had to go and attend to one of the four other residents in the home. For example on the 4th of August 2025, while transferring a resident from their bed to a chair, on two occasions a staff member asked the resident to lie back on their bed as they had to attend to another resident. The transfer took 2.5 hours in total. This occurred again

on the 11th of August 2025 with requests that the resident remain lying in bed until other residents were assisted. Additionally, there was an incident where a family member assisted with a personal care need of a resident as staff were not available at this time. When residents in the home were asked about waiting for staff, the residents stated that they knew that there were five residents in the home and that they had to wait, with one resident stating 'they tried to help out as much as they can'.

The numbers of staff were insufficient in this home and were posing a risk to the level of safe care available.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, inspectors found that the provider had not ensured that effective systems were in place for governance and management in this centre. Cumulatively the level of non-compliance found on inspection indicated that the systems in place were not robust or effective in identifying areas of improvement and ensuring safe care was delivered at all times.

Although the provider had identified some of the risks in relation to not meeting one residents' needs, such as fire risks, there had been limited effective actions taken to date to rectify this.

The provider did not demonstrate that the centre was fully resourced to meet residents' needs. There was insufficient resources in place in terms of staffing as addressed in Regulation 15: Staffing, and also limited resources in terms of Multi-Disciplinary (MDT) support as reported under Regulation 5: Individual assessment and personal plan.

An interim person in charge had been appointed to the centre who had a large managerial remit which. Previous inspections in the centre had identified this issue and the impact this was having on the levels of compliance within the designated centre. Following an inspection in February 2024 the provider had committed to restructure the designated centre to reduce the administrative burden on the person in charge. They had stated that the relevant application to complete this process would be submitted by the 30th of April 2024. This application had not been submitted.

An urgent action was issued to the provider on the first day of the inspection as there was no way to lock the doors in three bathrooms in one of the houses. There were keyholes but no keys available to either residents or staff to lock them. A staff reported that some residents would prop a stool in front of the door so no one could enter the bathroom when in use. In addition, the privacy covering on one bathroom was peeling and did not fully cover one bathroom window. Assurances were sent by the provider after the inspection that thumb locks had been installed on the three

bathroom doors and the privacy screen had been replaced. However, the providers systems had completely failed to identify or address this issue.

On review of the limited input and referral to health and social care professionals in relation to supporting residents specific needs, there was a lack of sufficient follow up. For example, a resident attended an appointment with psychiatry in November 2024. The outcome of this appointment was that the resident was to be reviewed following the Christmas period. This follow up appointment had not occurred. There was an overall lack of oversight and management of these processes and the systems in place were not effective in ensuring accurate information was available.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that the local management team were experiencing significant challenges to deliver a safe and consistent care and support for residents in this centre due to the changing needs of some of the residents within the designated centre. Significant improvements were required across the regulations reviewed with key regulations relating to care and support not meeting the minimum threshold of compliance. This was having a direct impact on aspects of residents' lived experience.

Inspectors found that improvements were required to ensure that incidents relating to allegations and suspicions of abuse were recognised and reported in line with the provider's and national policy, to ensure that residents' needs were assessed and reflected in their plans and to ensure that there were effective systems for the assessment, management and ongoing review of risk in the centre.

As previously stated the assessed needs of some residents were not being met. There was limited input and guidance from health and social care professionals in relation to changing and emerging needs. Residents' personal plans were not being updated in line with changing needs. The inspectors were not assured that all residents' needs could be met in the designated centre.

Not meeting residents' assessed needs was having a direct impact on the level of risks presenting in the centre. Although the provider was aware of some of the presenting risks, such as fire there had been limited effective actions taken to date to mitigate the risk. In addition, there were other poor practices in relation to risk management such as risks not being identified, risk assessed or managed through the providers risk management systems.

The provider had safeguarding and protection policies and staff had completed safeguarding training. However, inspectors identified incidents which had occurred in the centre that had not been recognised or reported as safeguarding concerns. In addition, one resident told an inspector that they were experiencing difficulties

sharing their home with their peers, and with some of their interactions with a staff member.

Aspects of the premises required review and updates to ensure the homes were maintained to a good standard and kept clean.

Regulation 17: Premises

Inspectors completed a walk around each of the four premises during the inspection and found a number of areas where maintenance and repairs and enhanced cleaning were required.

Some examples of where enhanced cleaning and maintenance and repairs were required included:

- An area on the ceiling above a shower in one bathroom contained black mould,
- Moisture damage to the flooring in one residents' bedroom and damage to the flooring in another residents' bedroom in one house,
- Damaged leather furniture in one living room which was impacting the ability to clean it,
- Damaged wooden furniture in two bathrooms in one house which was impacting the ability to clean it,
- A missing curtain pole and holes in the wall in a kitchen in one of the houses,
- Areas of three bathrooms and a kitchen where re-grouting was required,
- Door handles had been replaced on a number of doors throughout the centre and painting was required,
- There was chipped and peeling paint across many aspects of each of the premises, particularly in relation to one premises
- Inappropriate items were being stored in a residents walk-in shower such as clean towels and clothing,
- A deep clean was required in one home with aspects of the premises not cleaned to a good standard, for example a build of of dirt, dust and debris in corners of the rooms, staining and marks on press and room doors, appliances and other equipment not being cleaned and evidence of dirt accumulating.

Overall, the inspectors were not assured that all aspects of the premises were being maintained to a good standard which was impacting the homeliness and cleanliness of the designated centre.

Judgment: Not compliant

Regulation 26: Risk management procedures

Risk management within the designated centre was not effective in identifying and managing presenting risks.

The risk register, and a sample of general and residents' individual risk assessments were reviewed as part of the inspection process.

On the centre specific risk register in one home, the risks in relation to a fire safety were risk rated at red (the highest level). The risk assessment on file was dated October 2024. This risk had been escalated to the senior management centre in May 2025 following a day time fire drill taking 23 minutes to complete in the centre. However, limited effective actions had been taken to address the risk and the local management team were waiting on a response in relation to two actions generated following this fire drill. Although some measures remained in place, such as serviced fire equipment, fire containment, additional fire exits from bedrooms and frequent fire drills, there remained a risk in relation to ensuring evacuation could occur in a timely manner. Three subsequent drills had occurred since this date with the next highest time recorded at 11 minutes and 42 seconds. This was not a tolerable risk within the centre and required review to ensure effective actions were in place.

The inspectors reviewed individual risk assessments that were in place in each of the houses. There was no up-to date guidance available to staff in relation to risk management as they had no access to the online risk assessments. In one home, on review of three residents' files there was a total of two risk assessments on file. One of the residents, who had significant needs in relation to mobility, transfers, fire risks, and maintaining skin integrity had only one risk assessment on file and this was related to poor mobility. This risk assessment did not account for all presenting risks. For example, the resident did not have a risk assessment in relation to skin integrity and was spending protracted time in bed or sitting on chairs and there was documented evidence on some presenting skin integrity issues. In addition, this resident had a fall in June 2025 resulting in medical treatment and there was no update to the risk assessment on file following this.

Based on a review of documentation, discussions with staff, inspectors found that risk assessments were not in place for presenting risks. These risks included those relating to infection prevention and control, safeguarding, and fire safety. Other examples included that risks identified in behaviour support plans which were not supported by corresponding risk assessments.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Overall, inspectors were not assured that all residents' needs were being met in the designated centre. The provider, although aware of this issue, had no overarching plan on how this was going to be addressed. The inspectors were informed that a

business case had been submitted to their funder three years previously in relation to the deficits of care in the designated centre. The outcome of this business case remained outstanding.

Over the course of the inspection, inspectors were told and reviewed numerous documents completed by the provider that indicated that one residents' care and support needs could not be met in the centre. From a review of daily notes for this resident over the month of August, due to a decline in their mobility, transferring the resident from a bed to chair or vice a versa ,was taking a very long and protracted time. During this period there was seven recorded transfers of over a one hour duration. On four occasions the resident had experienced episodes of incontinence and their personal needs were unable to be attended too (despite staff trying to assist during this time). Although the time to transfer the resident had increased recently, there were similar patterns identified in previous months.

There had been minimal input from health and social care professionals in relation to the changing needs. On review of the records on the resident's file it was recorded that they attended the GP, Optician and Dentist in 2025. There was no record on their file in relation to supports from other professionals such as Physiotherapy or Occupational Therapy in recent months. An overarching document had been complied which outlined the history of supports that had been put in place for the resident. This was presented to the inspector on the day of inspection. On the document it stated that the last input from Occupational Therapy was in November 2023, a review by a physiotherapist occurred in November 2024 and Psychiatry in November 2024. There was no or limited corresponding notes or reports in relation to these appointments on the resident's file. The person in charge confirmed that the only referral at the time of inspection was to Occupational Therapy and this was to review the layout of the room. There was a lack of effective input from a MDT in relation to supporting the resident and informing care plans and supports.

The lack of MDT support was also evident in relation to other residents' needs not being met in a timely manner. For example, there was a medication prescribed for one resident by a psychiatrist. The medication had associated risks in relation to impacting the long-term health of the individual. Although oversight was in place from a general practioner (GP), the medication had not been reviewed by a Psychiatrist since 2020.

In addition, inspectors were not assured that residents' needs had been appropriately assessed. Across the sample of seven residents' plans reviewed, there was no comprehensive assessment of need available. Some residents had attended appointments in relation to specific health needs and personal plans were not updated on foot of these appointments. For example, the inspectors reviewed a report from a speech and language therapist which recommended specific follow-up appointments. There was no record on the resident's file if the follow-up occurred. The person in charge later confirmed that the follow-up appointments had taken place, however the residents' file had not been updated to reflect this.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that the provider had failed to recognise, respond to and address resident safeguarding issues in this centre.

Inspectors completed a review of a sample of residents' daily notes, incident reports and complaints within the centre from January to August 2025 and there were there were two documented incidents and a complaint that fell under the threshold of a potential safeguarding concern that were not identified as such, investigated or reported to the relevant agencies as required.

As previously mentioned, one resident told an inspector that they were experiencing difficulties sharing their home with their peers, and with some of the interactions between themselves and a staff member. They referred to times where peers were shouting at them and telling them what to do, times when their peers were up late at night and making noises which was upsetting them and impacting their sleep. They also and spoke about how another peer would not go to bed until they so which was impacting on their freedom of movement in their home and their ability to go to bed when they wished to. They indicated they had previously raised their concerns in the form of a complaint and said they had again recently raised their concerns to a member of the local management team. This was brought to the attention of the provider during the inspection who provided a number of immediate supports to the resident. They provided inspectors with the complaint the resident had raised in March 2025. The contents of the complaint had not been recognised or reported as a safeguarding concern. In addition, inspectors were informed that the concerns raised by the resident to staff in the weeks before the inspection, had not been raised to the centres management. This did not provide assurance that safeguarding issues were being appropriately reported.

Inspectors reviewed one residents' behaviour support plan which indicated there was a risk they may enter their peers bedrooms and remove their personal items. Inspectors spoke with staff and reviewed daily notes which demonstrated that this was occurring. This had not been risk assessed or considered from a safeguarding perspective by the provider.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for MooreHaven Centre (Tipperary) DAC OSV-0003723

Inspection ID: MON-0047992

Date of inspection: 15/08/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The necessary funding to support the required staffing levels, including waking cover required within one individual home of the designated centre, has been the subject of constant engagement between the Provider and its Funder, the HSE, so that the Funder can provide the necessary funding to satisfy the care needs advised by the assessment of needs. Further engagement is scheduled with the Funder on this matter on 22 October 2025. It will be emphasised to the Funder if the required care requirements continue to be unfunded the Provider may be left with no other option but to consider a discharge from services in line with the organisations Admission, Discharge and Transfer policy. This will be completed by 31 Dec 2025 • The Funder will be advised that failure to provide appropriate funds to meet the care requirements presented by residents within the designated centre will create significant uncertainty as regards the future registration of the centre. All comprehensive assessments of needs are updated and in order. Physical copies have been placed on each resident's files. Assessments will continue to be stored electronically on the Provider's central filing system. Such a step ensures assessments are available to all staff within each home. This action was completed by 2 September 2025	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To assist with the governance of the designated centre the Provider, MooreHaven have • The Provider has recruited a PIC, who is very aware of the service and their residents from her previous employment with the Provider. The PIC has commenced employment on 8 October 2025. • The Provider will support this PIC role by ensuring dedicated administration hours are	

made available to each Team Lead within each of the four homes involved in the designated centre. This will be completed by 31 Dec 2025
• The duties of each of the fifteen Social Care Workers employed by the Provider is being reviewed in line with the CORU standards of proficiency for Social Care Workers and will ensure these duties are structured correctly to ease the burden on the current PIC. This will be completed by 31 Dec 2025.
• All roles will continue to be supported by the Integrated Service Manager, whose role remains an active and key part of the residential management function and ensuring standards meets expectations.
• Each process used with the internal monitoring inspections (completed by key workers, team leads and PIC) and governance audits (mid-year and annual reviews) of the designated centre will be updated to strengthen regulatory compliance in line with the most recent inspection. This will be completed by 30 November 2025.
• The CEO holds responsibility for escalation of matters raised from any inspections or any other matter of concerns arising from residential leadership meetings to the Board and the Funder to support the progression of full compliance within the Health Act. HIQA compliance will be a standing item on the Board agenda effective immediately.

Regulation 17: Premises	Not Compliant

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

• The Provider's maintenance function has received a schedule of works to complete. All other matters as noted in the report continue to be addressed as part of his regular maintenance program. This action was completed by 1 Sep 2025
• The door locks have been addressed in the designated Centre, and the smaller portion of the privacy screen has been replaced where it was peeling slightly from the window. Completed 16 August 2025.
• The maintenance person has been added to the online reporting system to ensure they get a direct notification of maintenance requests from each home to facilitate a timely response. This action was completed by 1 Sep 2025.
• Audits schedules and terms of reference are amended to include areas such as chipped paint, cracked leather furniture and other matters. Completed 25 September 2025.
• The Provider has committed financial resources to address any remaining outstanding matters in one home within the designated centre. These funds are to be used to redecorate the house, new kitchen flooring and modernise this home. These works have commenced with the intention they will be completed by 31 December 2025.
• With regards to the absence of a toilet seat in the resident's en-suite, the resident who has cerebral palsy, has made an informed choice not to have a seat fitted. Staff have offered various seating options on multiple occasions; however, this resident has consistently requested that any toilet seat be removed. This preference has been respected in line with the residents' right to make personal choices about their care environment. A risk assessment has been carried out to support the resident's safety in this area. This action was completed by 30 Sept 2025.
A deep cleaning of the home identified in the report has been completed on 29 September 2025. Furthermore, a deep clean will now be provided across all locations at the end of each quarter. This will be completed by 31 December 2025.

Regulation 26: Risk management procedures	Not Compliant

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

• Policies and guidelines, including Risk, have been and will continue to be available on Vi Clarity, being a system providing governance risk and compliance material. All staff involved in the residential designated Centre have confirmed that they have read the Risk Management policy and their understanding of their obligations. Completed 31 August 2025.
• On online platform to access Risk Assessment will be made available to each member of the residential team, to be completed by 30 Nov 2025.
• All risk assessments have been reviewed and placed in each resident's file. Members of the residential team in each location have signed each risk assessment to ensure that they are aware of the risks and the control measures for each resident they are supporting. This action was completed by 30 Sept 2025
• The residential team, under the supervision of the ISM and the PIC continue to review each resident's risk assessment to ensure these assessments are appropriate. This will be completed by 15 November 2025.
• The ISM will be working with the PIC and the wider residential team to review and update overarching risk assessments for each home as regards their appropriateness for the circumstances contained in the house concerned. This will be completed by 31st Oct 2025
• The corporate risk register will be informed by any risks associated with residents assessed care needs. Escalated risks will be reported by the CEO to the Board of the provider and Board resolution followed through. This will be completed by 30 November 2025.
• Training programmes have been scheduled to enhance staff responsibilities in relation to safeguarding duties and obligations and the assessment and reporting of risks. This will be completed by the 30 October 2025.
• To mitigate the fire risk the Provider has invested in a profile bed and mobile chair to assist with the fire evacuation in the home identified within the report. The exit door in the resident's room has been enlarged to support a bed evacuation in the case of emergency. These have been completed by 31 August 2025.
• The fire service carried out a familiarisation visit in the designated Centre. The layout and floor plans of the home was shared with the attending fire service who visited each room within the unit. Additionally, the profile of each resident was shared and discussed with the fire service attending. Completed 15th April 2025.
The Provider is scheduled to engage with the Funder, the HSE, to again review the unfunded care needs of residents. It will also be emphasised to the Funder if the care requirements of this individual are not appropriately funded the Provider may be left with no other option but to consider a discharge from services in line with the organisations Admissions, Discharge and Transfer policy. This will be completed by 31 Dec 2025.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual

assessment and personal plan:

• Comprehensive assessments have been placed on each resident's files. Assessments will also continue to be stored electronically on the Provider's central filing system. Completed 2 September 2025.
• These assessments, which form part of the residents personal plan was reviewed between the PIC and each of the individual house teams was completed on 30 September 2025 and will continue to be reviewed as part of the residential team meetings.
• Personal Plans have been and will continue to be are reviewed between the PIC and each of the individual house team leads on 30 September 2025 and will be kept up to date.
• Once off funding has been confirmed by the HSE on 1 October 2025 for the engagement of Behaviour and Occupational Therapist services. The search for these services has commenced with appointment expected within six weeks. Research of how these services can enhance the service and benefit the service users supported by the Provider with mild to moderate disabilities will inform the Board regarding the sustained availability of these services. The residential team under the supervision of the ISM and PIC's will engage with the Occupation and Behavioural Therapists.
• The Provider is scheduled to engage with the HSE to again review the care needs of the resident consistently referenced in this report. It will also be emphasized to the HSE if the care requirements of this individual are not appropriately funded the Provider may be left with no other option but to consider a discharge from services by the end of 2025.
• The residential team continue to work proactively with the relevant medical professionals involved in residents care to ensure medical appointments are scheduled within the envisaged time frame. Any delays, challenges and outcomes will be recorded by the PIC supported by the residential team. This will be completed by the 31 Oct 2025.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

.• All staff have completed the HSELand safeguarding training and the HIQA on line safeguarding training.
• To further support this training all staff will now attend an in-person workshop to support a better understanding of safeguarding and to ensure safeguarding concerns are reported appropriately and in a timely manner. This will be completed by 30th Nov 2025

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.	Not Compliant	Orange	31/12/2025
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.	Not Compliant	Orange	31/12/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	31/12/2025

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/12/2025
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	31/12/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2025
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Red	08/10/2025

	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.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/12/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	02/09/2025
Regulation 05(3)	The person in charge shall ensure that the designated centre	Not Compliant	Orange	31/12/2025

	is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	02/09/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/10/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/10/2025