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:	A Canices Road
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Announced
Date of inspection:	08 April 2026
Centre ID:	OSV-0002332
Fieldwork ID:	MON-0041359

About the designated centre

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

A Canices Road is a designated centre operated by St Michael's House, located in North County Dublin. It provides community residential services to six adults who have varied support requirements. The centre is a two-storey house comprising a living room, kitchen/dining room, utility room, three bathrooms, an office and six bedrooms. There is a well maintained enclosed garden to the rear of the centre. The centre is located close to local shops and transport links. The centre is staffed by a person in charge and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Wednesday 8 April 2026	10:00hrs to 17:45hrs	Caroline Meehan	Lead

What residents told us and what inspectors observed

This announced inspection was completed to assess the provider's compliance with the regulations. The provider had submitted an application to the Office of the Chief Inspector of Social Services (Chief Inspector) to renew the registration of this centre for six residents. On the day of inspection there were six residents living in the centre, and there were no vacancies.

The centre was located in the suburbs of the city, and comprised a two-storey property, with parking to the front of the premises. The centre was close to public transport, and the centre had it's own car for residents' use.

The inspector had the opportunity to meet five of the residents over the course of the inspection. Residents appeared relaxed going about their daily lives, and staff were supporting them in line with their needs and preferences. For example, a resident, following a recent injury, was resting, and staff ensured the resident had their preferred programme on their television, and they had drinks and snacks available. Another resident was supported by staff at all times, and while staff explained the resident was offered opportunities for community activities every day, they mostly declined, preferring to stay in the centre, and this choice was respected.

Later in the morning the inspector spoke to a resident, as they were getting ready to go out. Staff explained the importance of supporting the resident with their verbal communication using picture prompts, as well as the resident's preference to visit places on ground level. The resident had several shops and places they liked to visit, and on the morning of the inspection they went out shopping with staff. A reflexologist visited the resident every fortnight for reflexology sessions.

Some residents attended day services, and the person in charge told the inspector a resident had recently completed work experience with a local company and they were starting use of public transport training.

Another resident told the inspector they were looking forward to a party in a nearby hotel to celebrate 20 years since the centre opened. Residents were supported to develop goals and met with their keyworker regularly to review plans to achieve goals. As part of their goals residents had been on a number of holidays the previous year, and had more holidays planned for the upcoming summer. Residents also liked to go to rugby and football matches, concerts, meet up with their families, and go shopping.

It was evident that staff knew residents well, and helped them plan their day according to their choices and needs. For example, a staff member described the importance of providing one-to-one time to one of the resident's when they came home in the afternoon, talking about how their day went, having a cup of tea at this

time, and providing fidget toys. This in turn helped the resident with their emotional wellbeing and was in line with the details set out in their personal plan.

At all times staff were observed to be supportive and kind in their interactions with residents, and there was a homely and engaging atmosphere in the centre. Visitors were welcomed in the centre, and residents met up with their families regularly. As part of the annual review in 2025, residents and families had provided feedback on the service provided in the centre, and positive feedback was received. For example, families expressed they were happy with the house and the care their loved one was receiving, that staff were respectful, and were responsive to the changing needs of a resident.

The next two sections of the report describe the governance and management arrangements in place and how these arrangements were impacting on the quality and safety of care and support residents in the centre.

Capacity and capability

Overall residents were being provided with an appropriate service; however, oversight arrangements required improvement in relation to fire safety.

There were sufficient staff numbers in the centre, and the provider had responded to the changing needs of residents by increasing staffing levels. Staff had the appropriate knowledge and qualifications to effectively support residents.

Suitable resources were provided, and the person in charge worked fulltime in this centre only.

While there were systems in place for monitoring the service provided to residents, the oversight of fire safety arrangements were not effective in responding to risks, and ensuring practices were in line with the provider's policy on fire safety, and with the Code of Practice for Fire Safety in New and Existing Community Dwellings, 2017.

As a result of this risk identified during the inspection an immediate action was issued to the provider and assurances were received verbally on the day of inspection and in writing on the day following the inspection, on the actions the provider was taking to ensure the safety of residents.

Registration Regulation 5: Application for registration or renewal of registration

A full application to renew the registration of this centre was received by the Chief Inspector.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was a qualified social care professional and had over 25 years' experience in a management role. The person in charge had an appropriate management qualification, and was responsible for this centre only.

The person in charge had one day supernumerary per week to complete administrative duties, and their remaining time was spent providing direct care and support to the residents living in this centre. The person in charge was supported in their role by a social care worker who was allocated one day supernumerary per month to also complete administrative work, for example, staff rosters.

The person in charge knew the residents well, and was knowledgeable on the supports residents required, as well as their responsibilities as per the regulations.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff employed in the centre, and staff had the appropriate skills and knowledge to meet the needs of the residents. The team comprised of social care workers, and the person in charge. There were three staff on duty during the day and two staff at night time in a waking capacity. The provider had responded to the changing needs of residents and recently increased the staffing from one to two waking staff. There was one staff vacancy in the centre.

The inspector met with two staff members and they outlined the identified needs of residents and the supports in place to meet these needs.

The inspector reviewed a sample of rosters over a three month period in 2026, and planned and actual rosters were available, and accurately reflected the staff on duty. Where additional staff were required these were generally filled by permanent staff or by a regular relief staff. The provision of consistent staff meant that residents were provided with continuity of care and support.

Staff files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 22: Insurance

The provider had up-to-date insurance for the centre, and a copy of the certificate of insurance was submitted to the Chief Inspector as part of the application to renew the registration of this centre.

Judgment: Compliant

Regulation 23: Governance and management

While overall residents were provided with a service in line with their needs, there was poor oversight of the safety arrangements, specifically fire safety. The lack of effective monitoring of fire safety arrangements meant that known risks were not assessed or mitigated, and fire safety practices required significant improvement.

There was limited evidence available to provide assurances that those responsible for oversight of fire safety were reviewing arrangements, in line with the centre policy on fire safety. As a result, there were inadequate arrangements for evacuation of residents from the centre, practising fire drills, and ensuring the most up-to-date information was available for staff to guide practice. These issues are further discussed in regulation 28: Fire precautions, and the actions the provider was required to take on the day of inspection.

There was a defined management structure and staff reported to the person in charge. The person in charge reported to the service manager, who was also nominated as a person participating in management. The person participating in management reported to the director of adult services and onward to the Chief Executive Officer.

Appropriate resources were provided including, sufficient staffing, a household budget and transport for residents' use. Some improvement was required in the upkeep of the premises.

The person in charge discussed the arrangements for auditing the centre. They outlined that daily and monthly finance audits were completed and weekly medicine audits, health and safety audits, fire audits, and infection prevention and control audits (IPC) were also completed. As mentioned, the arrangements for auditing fire safety were not appropriate.

An annual review of the quality and safety of care and support was completed for 2025 and had included consultation with residents and their representatives. Positive feedback was received from residents and their representatives. Actions had been

developed following this review and the inspector found these actions were completed.

A staff member outlined the can raise concerns with the person in charge regarding the care and support provided to residents, and the person in charge supported staff as a group with reflection of practice at monthly staff meetings.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose was available in the centre. However, on the day of inspection the statement of purpose was not reflective of some areas of service. Specifically, the staffing in whole-time equivalent, did not accurately reflect the revised staffing arrangements in the centre, and a change in the management reporting structure had not been amended in the document. This was pointed out to the person in charge and a revised statement of purpose was requested to be submitted to the Chief Inspector. The revised statement of purpose was not received up to the time of writing this report.

Judgment: Substantially compliant

Quality and safety

Residents were being provided with an effective service; however, risks relating to fire safety arrangements were not ensuring residents were kept safe at all times.

Fire safety arrangements in the centre required significant improvement, in particular the arrangements for evacuation of residents from the centre to a place of safety. The known risk related to use of an inner room as a bedroom had not been assessed or responded to appropriately, evacuation procedures were unclear, regular fire drills were not completed, and information used to guide fire safety practices was not up-to-date.

Residents' needs had been assessed, and personal plans were effectively guiding practice in the provision of health, social and personal care for residents. Staff were knowledgeable on the needs of residents and how best to support them in line with personal plans. Residents' rights in terms of their choices, privacy and dignity were respected, and residents were enjoying a varied lifestyle,

With the exception of fire safety, risks and incidents were effectively assessed and managed and where needed follow up actions were taken to ensure the safety of residents. There were no ongoing safeguarding concerns in the centre.

Regulation 13: General welfare and development

Appropriate care and support was provided to residents and residents were supported to access a range of opportunities in line with their preferences and goals.

Three residents were attending day service on the day of inspection, and one residents who usually attended day services was recovering post-surgery, and therefore staff were providing support with activities. Two residents were supported by staff to access community activities. Staff outlined the specific preferences of a resident, for example, the resident liked to attend three social clubs, enjoyed reflexology sessions in the centre every fortnight, and liked to shop in a specific shopping centre and a specific local supermarket. The person in charge also explained another resident attending day services was currently completing work experience and had started training in using public transport.

Residents met with their keyworker regularly, and as part of these meetings developed goals including social and community participation goals. Records clearly outlined the steps required to help residents achieve their goals, and the progress of goals was recorded. Residents had gone on holidays, went to a football club in England, went to music concerts, and had plans to go on holidays later in the year, go to a rugby match, and go away with family.

Residents were supported to maintain regular contact with their families, and either visited them at home, or their families visited them in the centre.

Judgment: Compliant

Regulation 17: Premises

The premises were suitable for its intended purpose and comfortably met the needs of the residents living there. Some minor improvements were required in the upkeep of the centre.

The premises comprised a large two-storey detached building with six bedrooms for residents' use. Each resident kept their own personal belongings in their rooms, and there was sufficient storage in rooms for these items. Residents like to display family photos, pictures of favorite bands, and posters of their goals for the year. One resident kept a digital picture frame with important memories, in their room.

There were sufficient bathrooms in the centre for residents' use including three bathrooms and one ensuite bathroom. One bathroom required upgrading and an occupational therapist had identified this need approximately two weeks prior to the inspection. The person in charge outlined funding would be sought from the funder. Some improvement was required to the upkeep of bathrooms on the first floor as radiators were observed to have rust on them. In addition, the bathroom on the ground floor was observed to have mold on the base of the shower.

Assistive devices and aids were provided where needed, for example, a shower chair, handrails, wheelchairs, and profile beds. The centre was fully accessible throughout.

There were suitable cooking and food storage facilities. A large kitchen dining room could accommodate all residents for their meals, and the kitchen area where food was prepared and stored was observed to be clean. There was a large utility room adjoining the kitchen and residents could launder their clothes there.

There was a large comfortable sitting room with a television and suitable seating, and to the rear of the property, a landscaped garden with a garden room. Residents liked to use the garden room particularly in the summer, enjoying outdoor dinners and music sessions.

There were suitable heating, lighting, and ventilation throughout the premises including in the garden room. Parking was available to the front of the premises.

Judgment: Substantially compliant

Regulation 20: Information for residents

An up-to-date residents' guide was available, and contained all of the required information including the arrangements for visits, how to access inspection reports, and the procedure regarding complaints.

Judgment: Compliant

Regulation 26: Risk management procedures

In the main, risks were being managed in the centre, and incidents were reported and followed up on appropriately.

A risk management policy was available and included the requirement to have risk assessments in place for the unexpected absence of a resident, self -harm,

accidental injury to residents, visitors, or staff, and for aggression and violence. The risk management policy was in-date and due to be reviewed in June 2026.

The inspector reviewed the centre's risk register, and two areas were identified as high risk or red rated, including aspiration and falls. The risk register had been reviewed by the person in charge and the person participating in management in February 2026 in line with the centre policy on reviewing high rated risks. The inspector discussed these risks and control measures with the person in charge and found control measures were in place. These included one-to-one supervision for a resident, a speech and language therapy review of a modified diet, and removal of risk items to prevent aspiration. The risk rating regarding falls had been informed by information received from a hospital consultant recently, and the inspector was assured that all reasonable measures were being implemented while the resident was awaiting further treatment.

While there were risks evident on the day of inspection related to fire safety, these are discussed in regulation 28.

The inspector reviewed records of incidents in 2026, and incidents were recorded in an online system and reported to the person in charge. The person in charge had reviewed incidents, and where needed, had referred incidents to healthcare professionals, implemented monitoring interventions, and ensured required maintenance was completed. All incidents were subsequently reviewed by the person participating in management and closed once no further action was required.

Judgment: Compliant

Regulation 28: Fire precautions

The arrangements for fire safety were not appropriate in the centre and could not ensure the safety of residents in the event of a fire. Suitable arrangements were not in place for the evacuation of residents to a place of safety, and for reviewing fire precautions. The procedures to be followed in the event of a fire were not clear and were not displayed in a prominent position. As a result of the risk identified the provider was issued with an immediate action on the day of the inspection.

The inspector was shown around the premises by the person in charge. The inspector observed that one ground floor bedroom was an inner room, and the exit from the bedroom led to a sitting room and not a protected corridor. This was discussed with the person in charge, who subsequently outlined they had discussed this with the provider’s fire officer. The fire officer agreed this bedroom was an inner room, however told the person in charge this was a low risk as the resident always had one-to-one support. However, while the resident did have one-to-one support during the day, at night time and since March 2026, two staff were on duty at night time, and prior to that time, only one staff was on duty. This meant that in the event of a fire at night time the resident did not have one-to-one support, and the

control measures the fire prevention officer outlined as in place could not be implemented. In addition, there was no evidence to confirm a fire drill had considered what to do in the event a fire started in the sittingroom adjoining the resident's bedroom, and no agreed arrangement on how to evacuate the resident in this scenario.

An immediate action was issued to the provider on the day of inspection requiring them to provide assurances on the actions they were taking to ensure the resident could be evacuated in the event of a fire, and these were verbally provided by the end of the inspection. A phonecall was made to the person in charge the following day; however, the person in charge outlined the assurances given the previous day could not be implemented. As a result, the inspector contacted the Director of Adult Services and requested written assurances on the actions that the provider was taking to ensure the safety of the resident, and this was provided in writing by the end of that day.

The inspector observed a handwritten floor plan on display in the hall; however, the fire evacuation routes were not clear. There was no fire evacuation procedure on display in the centre. A fire evacuation plan was available in the fire safety folder; however, this had evidently not been reviewed since 2023, and did not reflect the changing needs of residents, as well as day and night evacuation arrangements.

The fire folder was available for staff as a guide to use in the event of a fire; however, four personal emergency evacuation plans (PEEP) in the fire folder were observed to be out-of-date by two to three years. Two PEEPs were not available in the fire folder. This was discussed with the person in charge who directed the inspector to more recently updated PEEPs in residents' personal files, and most of these were found to be reflective of the needs of residents. However, one PEEP had not been reviewed to reflect the changing mobility needs of a resident. This was subsequently updated by the end of the inspection.

The assembly point to the front of the premises was not visible and this was discussed with the person in charge. On review there was no signage to indicate the assembly point, and staff were not clear on the agreed location. For example, one staff outlined residents would congregate to the front garden of the property in the event of the fire, while another staff stated residents would be relocated to the centre vehicle parked beside the front entrance door. Given the proximity of the vehicle and the front garden area indicated, to the premises, this was not an area of safety in the event of a fire.

An updated fire policy was not available in the fire safety folder, and the one available was due to be reviewed in January 2025. An up-to-date policy was subsequently located by the person in charge. The fire policy clearly outlined the responsibilities of service personnel for fire safety; however, the inspector found practices had not been implemented in line with the policy. For example, the policy stated the person in charge was responsible for ensuring a fire risk assessment was reviewed annually and all fire information was kept up-to-date. However, as discussed fire information was not kept up-to-date in the centre, and the person in

charge could not locate an up-to-date risk assessment. This was subsequently located in the risk register.

The policy outlined the service manager was responsible for monitoring fire drills and ensuring any issues were addressed promptly. However, on review of records, fire drills were not being practiced at regular intervals or in line with the centre policy of twice a year. Records indicated a fire drill had been carried out in March 2025, and again in March 2026 with an approximate 51 week interval between these drills. The person in charge said they understood a fire drill was completed in November 2025; however the person in charge could not locate the record of this drill. Given the responsibilities of personnel to ensure fire drills were monitored and issues addressed promptly, the inspector was not assured the oversight measures outlined in the fire policy were being implemented.

The fire policy also outlined the fire prevention officer employed by the service was responsible for conducting scheduled fire inspections, audits and reviews of the premises and provide a written report. The person in charge however was not aware of the fire prevention officer completing an audit or review. A fire feedback report dated May 2025 was made available to the inspector; however, it was unclear from the document who had completed the report. A number of actions arising from this review were found to be complete by the day of inspection; however, the action relating to information on the cut-off points for gas and electricity supply was not complete. There was no evidence to confirm the fire safety system in the centre including the safe evacuation of residents, fire drills, signage, assembly point arrangements, and guidance documentation for staff was subject to review or audit as per the centre policy. Nor was there any evidence to confirm the assessment and management of the known risk of an inner room.

The centre was equipped with a fire alarm, emergency lighting, fire extinguishers and a fire blanket, and fire doors were installed throughout the centre. All fire safety equipment had been serviced within the required intervals. All exits in the centre were observed to be clear from obstruction.

Daily, weekly and monthly fire safety checks were completed by staff including exits, fire doors, key boxes, fire panel and alarm, emergency lighting and drills, and all records were reviewed and signed off by the person in charge. The inspector observed records for February, March and April 2026 were complete.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' needs had been assessed, and there were personal plans in place based on these needs, and the recommendations arising from reviews by healthcare professionals.

The inspector reviewed two residents' files and spoke to two staff members who were assigned as keyworkers for these residents. Assessments of needs were up-to-date and assessments had included reviews with healthcare professionals, for example a general practitioner (GP), speech and language therapist, physiotherapist, clinical nurse specialist, and psychiatrist.

Personal plans were developed based on the identified health, social and personal care needs of residents and there was ongoing review of these plans to assess progress, and to amend plans to reflect any changing needs. Plans also included the development of goals and there was ongoing monitoring with residents and their keyworkers of the progress of goals.

From speaking with the two staff members, it was evident that they knew the residents needs very well, describing in detail the individual preferences of residents, as well as the care and support provided in line with the details set out in personal plans.

Judgment: Compliant

Regulation 6: Health care

Residents had timely access to healthcare professionals and there was ongoing monitoring of their health care needs.

Residents could access a range of healthcare professionals including their GP, speech and language therapist, physiotherapist, psychiatrist, and dentist, and ongoing review appointments had been facilitated with these professionals. The recommendations following reviews with healthcare professionals were set out in healthcare plans and were implemented in practice. For example, providing supervision to support a resident when mobilising, providing a modified diet, and completing monitoring interventions including blood pressure and sleep.

Judgment: Compliant

Regulation 8: Protection

Residents were protected in the centre and there were no ongoing safeguarding concerns.

The Chief Inspector had been notified of one incident of alleged abuse in the centre since the last inspection, and this incident had been recorded and managed appropriately. The inspector reviewed incidents since the last inspection and there were no ongoing safeguarding concerns.

The team in the centre had developed safeguarding plans as part of the personal planning process and these plans guided the practice in ensuring residents where protected. Staff were knowledgeable about the actions to take in the event of an allegation of abuse including the reporting requirements, and the measures to ensure residents safety.

Judgment: Compliant

Regulation 9: Residents' rights

The organisation of this centre was based around the known preferences and needs of residents, and the team working in the centre were providing support that ensured the privacy and dignity of residents was respected.

Residents made their choices about what they would like to do on a day-to-day basis and as mentioned, some residents attended day services while other residents were supported by the staff team with their choice of activities. A staff member described how a resident makes their own choices every day and staff facilitated their preference, for example, going shopping in preferred stores, going to various social clubs and going on holiday with family. It was important to residents that their preferences were respected, for example a preference not to use facilities with stairs.

The support residents needed with personal care was detailed in intimate care records and staff made every effort to ensure residents' skills and understanding of support were communicated. For example, picture guides to communicate to a resident what was happening next were in place for a range of personal care interventions. This in turn had supported the resident to maintain their current skill level while providing predictability during these care interventions,

Suitable arrangements were in place to store residents' personal information.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for A Canices Road OSV-0002332

Inspection ID: MON-0041359

Date of inspection: 08/04/2026

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The Organisation Fire Officer completed a review of the Centre Emergency Folder on 14/04/2026 in advance of the annual fire training and inspection completed on 13/05/2026. Findings were communicated to the Person in Charge (PIC) and Local Unit Fire Officer (LUFO), and all identified actions were reviewed and addressed.

• A sign-off system has been introduced within the Emergency Folder to record completion of annual fire audits, reviews and associated actions. Individual fire documentation includes review dates which will be used as evidence of reviews. The PIC is responsible for maintaining records and ensuring all documentation remains current in the emergency folder.

• The Service Manager completes two six-monthly audits annually, which include a review of fire safety documentation, evacuation arrangements, fire drills, Personal Emergency Evacuation Plans (PEEPs) and compliance with fire safety procedures. In addition, two Quality and Safety Audits are completed annually, which include review of fire safety systems and practices.

• The Organisation Fire Officer completes an annual fire inspection of the designated centre and provides a written report with recommendations and required actions. Compliance with actions will be monitored through the centre governance structures and reviewed by the Service Manager.

• To strengthen independent oversight of environmental fire safety arrangements, the organisation as part of commissioning its stock conditional survey, will include a fire compliance review against current building regulations. Procurement is underway.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• A revised Statement of Purpose was submitted to the Authority on 15/5/26

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The PIC will submit a Maintenance request to address the rust on the radiator in the upstairs bathroom and the mold identified in the main bathroom downstairs.
• The PIC and SMH Maintenance Department will submit a grant application to DCC to fund the necessary works

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In response to non-Compliant under Regulation 28 the following actions have been taken:
• Following consultation between the Person in Charge (PIC), Service Manager, Fire Officer and multidisciplinary team, a comprehensive review of the evacuation arrangements for the resident occupying the inner room was completed.
• A risk assessment was undertaken to evaluate available options and determine the least restrictive and safest solution for the resident. It was agreed to remove the stud wall between the resident's bedroom and adjoining sitting room, creating a larger bedroom area and eliminating the inner room arrangement. This modification will provide the resident with direct access to the circulation route leading to the final exit and will remove the requirement to travel through another room during evacuation. Pending completion of the environmental works, the following interim control measures have been implemented:
• The television, identified as the primary ignition source within the adjoining sitting room, has been removed, significantly reducing the fire risk within this area.
• An additional fire extinguisher has been provided within the area as an interim to support staff response where safe to do so; however, evacuation remains the primary response in the event of fire.
• The night-time evacuation plan has been reviewed and updated to reflect the presence

of two waking night staff members, ensuring sufficient staffing resources are available to support evacuation.
• The updated evacuation procedure for the resident has been communicated to staff and practised during annual fire training completed in May 2026. This included a fire scenario involving the adjoining room pending completion of the environmental works. Interim controls completed 31/05/2026. Building works to be completed by 30/08/2026. The completion date reflects contractor availability and the requirement to coordinate building, electrical and decoration works while minimising disruption to residents. Application to vary to be submitted within four weeks of completion of works.
• A trial arrangement has commenced whereby the resident's bedroom and adjoining room function as one space pending completion of the environmental works, reducing the risks associated with the former inner-room arrangement.
• Safety improvements have been completed to the front bedroom window to support the resident's assessed support needs following the room reconfiguration.
• These interim controls have been risk assessed and will remain in place until the environmental works have been completed, and the revised layout formally approved.
• A fire drill incorporating the evacuation of the resident from the revised room configuration will be completed following completion of the environmental works, and any learning identified will be incorporated into the resident's Personal Emergency Evacuation Plan (PEEP) and the centre evacuation procedures.
• Following completion of the building works, updated floor plans will be obtained and submitted as part of an application to vary the centre floor plans with HIQA.
• The centre evacuation plan has been fully reviewed and updated to reflect current resident support needs, staffing arrangements and day and night-time evacuation procedures.
• All residents' Personal Emergency Evacuation Plans (PEEPs) have been reviewed and updated by the PIC and keyworkers to ensure they accurately reflect current mobility, communication and support requirements. Copies are maintained in the Emergency Folder.
• A clearly identified assembly point has been established at the front garden wall. Appropriate signage and visual identification measures will be installed, including the placement of a garden bench to clearly identify the location for residents, staff and visitors. Pending installation of permanent signage, the assembly point location has been communicated to all staff and residents and is clearly identified within the evacuation procedure.
• The revised evacuation plan is displayed prominently within the centre and is available within the Emergency Folder.
• Fire evacuation training completed on 13/05/2026 included practical evacuation exercises to ensure staff were familiar with their responsibilities and the revised evacuation arrangements. All staff have signed to confirm understanding of the revised procedures
• The fire evacuation procedure has been reviewed and updated to reflect the revised night-time staffing arrangements, updated evacuation procedures, assembly point location and actions arising from fire safety training and risk assessment.
• The revised procedure is prominently displayed within the hallway and maintained within the Emergency Folder. Updated floor plans and evacuation routes have also been displayed to provide clear guidance to staff, residents and visitors.
• All Personal Emergency Evacuation Plans (PEEPs) have been reviewed, updated and transferred to the Emergency Folder. As part of the quarterly PIC fire checklist the PIC

will ensure all evacuation information remains accurate, current and reflective of residents' assessed needs.
• All staff have reviewed and signed the revised evacuation procedure and have demonstrated understanding of their roles and responsibilities through practical fire evacuation training.
• Annual fire evacuation training and regular evacuation drills will continue to provide assurance that staff can effectively implement the fire evacuation procedures and support the safe evacuation of residents in the event of an emergency. Documentation will be maintained within the emergency file.
• To provide assurance regarding the effectiveness of evacuation arrangements and compliance with organisational policy, a night-time fire drill incorporating the revised staffing arrangements and evacuation of all residents will be completed by 30/09/2026. This will ensure reasonable timeframes between drills and internal policy requirements.
• The drill will specifically assess evacuation arrangements for the resident previously accommodated in the inner-room configuration and will include a review of evacuation times, staff responses and any learning identified. The drill and outcomes will be documented and incorporated into the centre's fire safety arrangements and resident evacuation plans where required.
• Thereafter, fire drills will be completed at intervals not exceeding six months and will include both daytime and night-time scenarios, varying fire locations and resident-specific evacuation requirements.
• Fire safety awareness continues to be promoted through weekly resident meetings, where fire evacuation arrangements are discussed. Residents also participate in regular evacuation walks using alternative escape routes to increase familiarity with evacuation procedures.
• All fire drills will be documented, reviewed by the PIC and monitored through governance audits to ensure compliance with organisational requirements and to identify and address any emerging risks.

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 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.	Substantially Compliant	Yellow	30/12/2026
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.	Substantially Compliant	Yellow	30/09/2026
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/09/2026

Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/09/2026
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	12/06/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	12/06/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	12/06/2026
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.	Not Compliant	Orange	30/09/2026
Regulation 28(5)	The person in charge shall	Not Compliant	Orange	12/06/2026

	ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.			
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	12/06/2026