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:	Newbrook
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	21 January 2026
Centre ID:	OSV-0002344
Fieldwork ID:	MON-0048079

About the designated centre

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

Newbrook is a designated centre operated by St. Michael's House. The centre is based in a North Dublin suburban area and provides full-time residential care and support to two residents with intellectual disabilities. The designated centre is comprised of a two story semi-detached property with a modest sized garden to the front and side. Both floors have their own private entrance in a porch area accessible through the main door. The ground floor consists of an entrance hall, a bathroom, a storage area with laundry facilities, a kitchen and dining area, a sitting room and a double bedroom. On the first floor there is a sitting room, a small kitchenette with dining space, a bedroom with en-suite facilities, a main bathroom, a toilet and wash hand basin, a staff office and sleepover room, and a small storage room with laundry facilities. Residents are supported by a staff team of social care workers, direct support workers and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 21 January 2026	10:00hrs to 18:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This was an unannounced inspection, carried out to monitor the provider's compliance with the regulations and to follow up on actions the provider committed to completing after the last inspection where a high number of non-compliant Regulations were identified.

The person in charge was on leave on the day of the inspection. A social care worker, who also participates in management at a local level, as well as the senior service manager, facilitated the inspection.

The designated centre is registered to accommodate two residents. Over the course of the inspection the inspector had the opportunity to meet with the two residents. They also met with one of the resident's family members who were visiting them that afternoon. The inspector used observations and interactions with residents, in addition to a review of documentation and conversations with staff, to form judgments on the residents' quality of life.

Overall, the inspector found that there had been minimum progress on completing a number of the actions that were required to bring the centre back into compliance in relation to the premises, staffing and protection. This meant that residents were continuing to live in a home where the layout of the premise was not meeting their needs. In addition, residents were not in receipt of continuity of care, which was impacting on building and maintaining relationships to make they feel secure and safe in their home. Furthermore, the risk of peer to peer safeguarding incidents remained on-going, which meant that residents were experiencing continuous negative outcomes in their home and overall, this was impacting on their health and wellbeing.

The centre comprised of a two story semi-detached property with a grassed garden area at the back and side of the house. One resident lived in the ground floor section of the house which was laid out as a single occupancy apartment and the other resident lived in the first floor section of the house, which was also laid out as a single occupancy apartment. There were restrictive practices in use to ensure that neither resident entered each other's homes. Both apartments had their own private entrance in a porch area that was accessible through the main door.

The ground floor apartment consisted of an entrance hall, a bathroom, a storage area with laundry facilities, a modest sized kitchen and dining area, a sitting room and a double bedroom. On the first floor there was a sitting room, a small kitchenette with dining space, a bedroom with en-suite facilities, a main bathroom, a toilet and wash hand basin, a staff office and sleepover room, and a small storage room with laundry facilities.

The physical configuration of the centre, allowed for both residents to live independently in their own apartments within the house. However, due to ongoing behaviours of residents, which included loud noises and banging on regular occasions, the layout of the designated centre was not meeting the needs of the residents and was resulting in ongoing safeguarding incidents occurring in the centre.

The premise was also observed to be in poor upkeep and repair. Infection prevention and control issues related to the state of repair, that had been identified on the last inspection, remained outstanding and in some cases had further declined.

One resident was happy to show the inspector around their apartment. The showed their inspector their sitting room where they watched television. The television was observed be placed behind a large timber frame with a perspex screen. The residents television room had been moved from one area of the apartment to another and this was in an effort to lessen noise levels impacting on neighbors. The residents bedroom was laid out in the way the resident liked and included a lot of toys and memorabilia that was of preference to them. On observing the resident's bedroom the inspector noted to the staff member that the room was very cold. The staff member informed the inspector that the heating was working effectively and at night time the residents room was warm.

The resident showed the inspector their kitchen and dining area which the inspector observed to need upkeep and repair, and in particular, to the walls in the room. The resident showed the inspector the notice board that included activity and menu planners and information on the staff members working each day. The inspector observed that the activity planner was not reflective of what the resident's plans were that day as well as the last two days. The resident showed the inspector their bathroom and the inspector observed it to be in poor upkeep and repair and had fallen in to further disrepair since the last inspection.

The resident said they liked their apartment. When asked, they told the inspector that they would speak with the person in charge if they were upset or had any concerns. When asked if the person in charge was on leave who would they speak with, the resident named a permanent member of staff.

The inspector met the other resident when they arrived home from their day service. The resident welcomed the inspector and sat with them for a brief period and relayed their views. The resident said they liked their home but did not like how noisy it was. The resident expressed their upset at the noise and banging coming from the other apartment. The resident became tearful when relaying their unhappiness about the impact their peer's behaviours were having on them. This is discussed in detail under Regulation 17 and 8.

The inspector met with two family members on the day of the inspection. They informed the inspector of a number issues they had about the quality of care and support their family member received. The family members raised concerns about the number of different staff members working in the centre and in particular, staff

that were unfamiliar to the resident. They were concerned that staff who worked on a less than permanent basis where not fully familiar with the resident's care and support needs but also their communication, eating and drinking and social needs. This is discussed in further under Regulation 15.

Residents were facilitated and empowered to exercise choice and control across a range of daily activities and to have their choices and decisions respected. Weekly resident house meetings occurred with the agenda including matters such as safeguarding, open disclosures, health and safety, assisted decision making Act, outbreak management plans, fire safety and complaints. Resident were supported by their staff to relay their concerns through the complaint's process. On review of the complaints log the inspector saw that both residents had made separate complaints that related to the negative impact their peers behaviour was having on them.

The inspector met and spoke with the two staff members working on shift for the day. One of the staff member was a permanent member of the centre's team and the other staff member was new relief staff member. It was their first day working in the centre. On speaking with the relief member of staff just before lunch time, they told the inspector that they had read some of the information relating to the care and support requirements of the resident but they had yet to read more so that they were aware of all information.

In summary, the inspector found that the provider was not ensuring a safe or good quality service was being provided to residents living in this centre and it was resulting in negative outcomes for the residents living in the centre. Many of the issues found on this inspection had also been found on the previous inspection in March 2025 however, there had been minimal traction to bring quality improvements to the service.

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

Capacity and capability

The purpose of this risk based inspection was to monitor ongoing levels of compliance with the regulations and, to follow up on improvements made since the last inspection's poor findings.

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a quality and safe service was being provided to the residents living in the centre.

Overall, the inspection found that the provider had failed to ensure that residents were in receipt of a good quality and safe service, at all times. There had been a further decrease in the level of compliance with the Regulations since the last inspection and this was having a negative impact on the lived experience of residents.

Subsequent to the last inspection of the designated centre in March 2025, the provider was required to attend an escalation meeting with the Office of the Chief Inspector and provide assurances of bringing the centre back into compliance and particularly, in relation to deficits relating to premises, protection, staffing and fire safety. While the provider had made improvements to the fire safety measures in the centre, there had been insufficient action completed to bring the other Regulations back in to compliance. This was resulting in negative outcomes for the two residents living in the centre both in their home and community. In addition, this inspection found that other Regulations such as infection prevention and control to be non-compliant and as a result was putting the residents at risk of the spread of healthcare related infectious decease.

The provider had completed an annual review of the care and support provided to residents in the centre. In addition, the provider had completed two unannounced six monthly reviews of the centre during 2025 which included an action plan. At local level the person in charge completed monthly data reports, incident and accident trackers, health and safety checklists, medication management, fire safety, and infection, prevention and control (IPC) checks. However, on review of the action plans, the inspector found that not all audits were effective in providing quality improvements or in a timely manner.

The provider was not ensuring that the designated centre was appropriate to the residents' assessed needs. The inspector found that, due the layout of the physical environment, deficits in staff levels and the ongoing risk of safeguarding incidents, the provider was not ensuring that the centre was appropriate to the needs of residents, at all times.

Since the last inspection, there had been minimal progress made to the provisional plan, which had been in place since 2023, that would better support residents' needs and overall, likely reduce the continuance of safeguarding incidents occurring in the designated centre. On the day of the inspection, funding had not yet been secured. The timeliness of this action meant that the risk of ongoing safeguarding incidents was likely to remain in place for some time.

On review of the staff roster, the inspector found that a number of improvements were needed to ensure it was maintained appropriately. Staff vacancies had increased since March 2025 from 1.5 to 3 whole time equivalent (WTE) vacancies. The inspector found that the arrangements in place to cover the current staff vacancies were not ensuring continuity of care which was impacting on building and maintaining meaningful relationships between staff and residents as well as their families.

The registered provider had established a complaints procedure which was underpinned by a comprehensive policy. The complaint's procedure was available in an easy-to-read format and accessible to residents and their families. A copy of the procedure alongside information on advocacy was located in a communal space in both apartments. However, some improvements were required to the recording of complaints as well as the follow-up. This was to ensure that there was sufficient evidence to demonstrate progress of the complaint but also that the complainant wwas kept informed right throughout the process.

Regulation 15: Staffing

The provider had failed to ensure that the staffing arrangements in place in the centre were adequate in ensuring the safety and wellbeing of residents at all times. In addition, the provider had failed to ensure that all residents were provided continuity of care and in a fair and equitable manner.

The staffing arrangements in the centre included one to one staffing (lone working) to support each resident; One staff supported the resident in the upstairs section of the house and the other staff supported the resident in the ground floor section of the house.

The provider had recently recruited a social care worker however, on the day of the inspection, there was three staff vacancies in the centre. This was an increase in vacancies since the last inspection. The three vacancies were for one social care worker and two direct support workers.

To cover the gaps in the roster, staff from the organisation's relief panel, as well as agency staff, were employed. On review of a sample of rosters, the inspector found that the staffing cover arrangements did not ensure continuity of care. This was resulting in negative impacts for residents.

A sample of rosters during December 2025 and January 2026 demonstrated that during this period twelve different relief staff were employed. Three of the relief staff each worked 10-12 shifts however, the other nine relief staff primarily worked one shift over the two month period. This meant that while gaps in the roster were covered, continuity of care was not ensured and potentially impacted on promoting and maintaining relationships between residents and their staff.

The rosters showed that where relief and agency staff were employed, they were primarily allocated to work with the resident living in the upstairs apartment. There was no clear rationale for this arrangement as both residents had complex needs in terms of the care and supports they required. A review of this arrangement was needed to ensure fairness and transparency and to provide better continuity of care for the resident.

On speaking with the resident's family, they expressed their concern about the number of different staff working with their family member. They said they had

noticed that since June 2025, that core staff team members rarely worked with their family member. They said this was impacting negatively on their family member's behaviour but also as a family they found it difficult to build relationships and trust in staff that were unfamiliar to them. In addition, they expressed concern that staff were not familiar with the resident's needs and preferences due the inconsistent pattern or them working in the centre.

It was unclear from the sample of rosters how many agency staff had been employed during this period as during December 2025. The roster showed that agency staff covered five shifts however, as the agency staff were not named, it could not be ascertained if it was one agency staff or five. Three other agency staff who worked during this period were named however, for one agency staff member, there was no second name included. As the roster was not maintained appropriately, it meant that the provider could not be fully aware that the appropriate skill mix of staffing was in place to meet the number and assessed needs of residents.

Similar to the last inspection of the centre, in line with the provider's policy, the majority of staff, employed on a less than permanent basis, were not permitted to administer medication to residents in this designated centre. This meant that, during these times, the lone working permanent staff, supporting a resident in one apartment, were also responsible for administering medication to the resident in the other apartment. Once they administered the medication, they had to return to the apartment they were working in.

This was resulting in negative impacts for residents, and particular for the resident in the upstairs apartment as they often refused their medication. There was a procedure in place when the resident refused their medication, to firstly to respect their decision and then for staff to continue to offer the medication throughout the day in case the resident may change their mind. However, as the staff member administering the medication was working in the other apartment, this procedure was difficult to fully implement.

The staffing arrangements in place also resulted in other negative outcomes for residents. For example, staff who were employed on a less than permanent basis were not permitted to drive the designated centre's vehicle. On the day of the inspection, one resident told the inspector that they were going to stay in and watch television all day as it was raining. The relief staff member working with him told the inspector that they did not drive. As a result the resident's community activities were limited that day.

The inspector was informed, that where agency staff employed but were not trained in feeding eating and drinking (FEDS), they had to complete a FEDS online course at the beginning of their shift before working with a resident who had FEDS guidelines in place. This arrangements warranted review so that the provider could be assured that staff supporting residents with FEDS requirements, were sufficiently skills and experienced in providing this type of support to them.

There was an 'essentials' folder in place for relief and agency staff to read and become familiar with. The folder included information on each resident's assessed needs, likes and preference. It included positive behaviour support plans and FEDS guidelines and information. There were no induction forms included in the folder. There was a record for staff to sign to say the read and understood the information. However, on review of names on the centre's December 2025 and January 2026 rosters, the inspector saw that not all staff working on a less than permanent basis had signed to say they had read or understood the information. This meant that the provider could not be assured that staff supporting residents were familiar with their support needs and in particular, how to support residents management their behaviours during times the were upset.

On the day of the inspection, a relief staff, who had never worked with one of the residents, was employed to work a lone-working shift from 8am until 9pm that evening. They had been given a brief handover from the night staff. They had been provided no formal induction, no shadowing period and told the inspector that they had only been able to get through some of the information in the 'essentials' folder. The resident was not awake when the sleepover staff left at 10am, so it meant that the resident was waking up in their home to be supported by a staff member they had never met before. This arrangement not only put the resident at risk, but due to the complex needs and behaviours of the resident, potentially put the staff member at risk also.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had failed to ensure that the service provided to residents living in the designated was safe, appropriate to their needs, consistent and effectively monitored at all times. This was resulting in negative outcomes for residents and overall, was impacting on their lived experience in their home and community.

The provider had implemented a number of oversight and monitoring systems in the centre, however, the inspector found that some of the systems were not effective in ensuring timely and quality improvements.

The last inspection of the centre had identified that many areas of the centre required upkeep and repair which were impacting on the infection control measures in place. Local and provider-led audits, such as the monthly data report's infection prevention and control audit (from May to November) and unannounced six monthly review of the quality of care and support provided to residents, all referred to poor upkeep and repair in the centre. However, there had been no satisfactory response to these issues which meant the issues remained outstanding. This posed a potential risk to residents in terms of the risk of spread of health-associated infections.

The provider was not ensuring the layout of the designated centre's premises was meeting the residents' assessed needs and in particular, their health, safety, and wellbeing needs. Since the last inspection, further safeguarding incidents had occurred in the centre which was impacting on the lived experience of residents. Furthermore, the impact of a safeguarding incident in July 2025 meant that the environment and location of the centre, was putting one of the residents at further risk of negative outcomes. This is discussed in detail under Regulation 17.

The provider had commenced the process of changing the layout of the centre, through potential additional on-site accommodation however, there had been minimum traction of these plans since the last 10 months. These plans were part of a resident's safeguarding plan to better meet their needs and reduce the risk of negative impacts for both residents. Overall, the timeliness of the provider to progress these plans was not satisfactory. Furthermore, due to the impact of recent safeguarding incidents, there was a concern that if this measure was to proceed, it may not be effective in achieving positive outcomes for resident.

The service provided was not consistent. The provider had failed to resource the centre to ensure the effective delivery of care and support in accordance to the statement of purpose. There were staff vacancies in the centre and the arrangements in place was not ensuring safe and consistent delivery of care and support to the residents at all times.

Judgment: Not compliant

Regulation 34: Complaints procedure

On the day of the inspection there were five open complaints and these were included in the centre's complaint's log. The inspector reviewed a sample of two complaints. One complaint was made by a resident in May 2025 and the second complaint was made by the other resident in July 2025. Both complaints related to the noise levels coming from the other apartment. The complaints noted how the noise was impacting on them negatively and in particular, for one resident, during the night time which was disturbing their sleep. Overall, the complaints related to ongoing safeguarding concerns in the centre.

The sample of complaints viewed by the inspector were at status "on-going". The complaint form noted the details of each of the complaints and one form noted that a review had been carried out, however, there was no information about the review. There was no action noted on the other complaint form.

Overall, the inspector found that there was minimum information on the complaint forms to demonstrate if and how they had been addressed. There was no detail of consultation with either resident about the progress of the complaint or suggestion of a possible solution. Follow up from safeguarding incidents had been recorded in

other documents and plans associated with the care and support of residents however, the complaints log did not signposted or refer to these.

Overall, the inspector found that the complaints had not been followed in line with the provider's complaints procedures and process. Improvements were needed to ensure residents were kept updated on their complaint so that where any follow up or actions had been completed, it was clearly documented in the relevant records.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality and safety of the service for residents who lived in the designated centre.

The inspector found that the provider had failed to ensure that a safe and quality service was delivered to residents at all times. The findings of this inspection demonstrated that overall, the provider was not operating the service in compliance with regulations associated with staffing, premises, infection prevention and control and protection. Due to the risk of ongoing safeguarding incidents, residents were experiencing negative outcomes in their home and in their local community.

The physical environment of the house was observed to be in poor decorative and structural upkeep. The layout of the premises was impacting on the lived experience of residents; where behavioural incidents occurred, that included banging and loud noise, this was having a negative impact on the health and wellbeing of residents. In addition, the noise levels of the incidents were resulting in neighbours making complaints to the provider as well as external organisations, which also was impacting negatively on the residents.

Since the last inspection, there had been improvements to the fire safety measures in place in the centre. A number of improvements were made to the fire prevention systems as well as the oversight measures which mitigated against the risk of fire in the centre.

The inspector found that for the most part, the medicine arrangements and practices were appropriate and in accordance with the provider's associated policy. The person in charge was endeavouring to ensure that the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storing and disposal and administration of medicines. However, on the day of the inspection, improvements were required with regards to the labelling, storing and auditing of one resident's medication.

Since the last inspection, there had been minimum traction of improvement plans and measures that would like decrease the risk of ongoing safeguarding incidents

occurring. This meant that residents live experience in their home was not always positive. In addition, during 2025 a safeguarding incident that impacted a resident, as well as their neighbours, had resulted in negative outcomes, and potential risks, for both residents. Overall, the provider had not ensured that residents living in this designated centre were safeguarding at all times. There were a number of actions required by the provider to address this issue and until they were addressed the residents remained at risk of further safeguarding incidents and overall, poor outcomes and continued negative lived experience in their home and community.

Regulation 10: Communication

The person in charge was endeavouring to ensure that residents were assisted and supported to communicate in accordance with their needs and wishes. Both residents in the centre communicated and expressed themselves verbally. In line with one resident's preference, they sometimes chose to communicate using sign language. On speaking with a staff member, the inspector found that they were knowledgeable of residents' communication support needs.

Residents' personal plans contained communication care plans which detailed how best to support each resident in this area. On review of one resident's personal plan, the inspector saw that they were provided a communication support plan, communication sign-reading plan and a 'visual board to support communication' plan. The plans guided staff to know how each resident preferred to be communicated with, how they liked to communicate with people and how they made choices.

A family who spoke with the inspector expressed their concern about their family member not being able to understand or communicate with some of the relief and agency staff. On the day of the inspection, there was one permanent and one relief staff member. The inspector observed during different times of the inspection, residents expressing themselves, receiving information and being communicated with in the a way that met their assessed needs.

The inspector observed a lot of the signage in the centre was in easy-to-read, such as menu planner, daily and weekly planners and local community activities and events. There was a daily roster that included a photograph of the core staff team on duty that day and night.

Judgment: Compliant

Regulation 13: General welfare and development

The person in charge was endeavouring to ensure that residents were supported to engage in meaningful activities which promoted their personal development and

independence. Both residents were provided a choice of attending a community day service. However, where one resident was declining to attend their day service on a regular basis, it was resulting in negative outcomes for them.

The proactive strategies in a resident's positive behaviour support plan noted the benefit of the resident attending their day service as well as participating in community activities. The support plan stated that it had been well established that the resident was more likely to become dysregulated in their home environment compared to their day service or community setting.

On review of the resident's current and past weekly activity planners the inspector saw that day service was included each week from Monday to Friday. On the day of the inspection, as well as the previous two days, the resident had declined to attend the day service however, this had not been updated on the planner. This meant that the tracking of the residents activities was not effective and posed a risk to the effectiveness of positive behaviour support plan reviews.

On speaking with the resident, they told the inspector they had planned to watch television for the day. When asked about attending their day service the resident declined to respond. On speaking with staff, they informed the inspector that on a regular basis the resident was declining to go to the day service and was showing no interest in participating in community activities.

The inspector was also informed that lately the resident was presenting as very withdraw. On review of the October 2025 team meeting minutes, under the care and support provided to residents section, the inspector saw that during the previous month, the resident had sleep all day for seven days and was awake all night for six nights.

Overall, the inspector found that a review of one resident's choice of community activities and day service was warranted. This was to ensure that the resident was provided choice of activities that were meaningful and of preference to them and would likely encourage more community inclusion and participation. In addition, in line with the residents positive behaviour support plan, increased community activity was more likely to reduce the risks of incidents occurring.

Judgment: Substantially compliant

Regulation 17: Premises

On review of safeguarding incident reports, positive behaviour support plans and complaint forms, the inspector saw that the two residents living in the centre engaged in behaviours that resulted in loud noise, including banging on walls and shouting. These noises could be heard in all areas of the designated centre and was impacting negatively on the lived experience of both residents. For example, when

one resident shouted or banged walls upstairs, this could be heard in the downstairs section of the house, including the resident's bedroom and the staff sleepover room.

In addition, on speaking with staff and management, the inspector was made aware that the noise could also be heard by neighbours, who had made numerous complaints. As the noise was on-going, this was impacting on the relationship between the residents and their neighbours and was resulting in poor outcomes for the residents.

During the previous inspection the provider advised of a potential plan to increase the size of the centre by adding an on-site single occupied apartment. The provider had applied for planning permission and funding from the local city council. While the planning permission had been accepted there was no outcome to date of the funding. The status of the funding remained the same for the past ten months.

On the day of the inspection, the inspector was informed that further information had been requested from the local city council however, there was no indication how much longer the outcome of the decision would take. The inspector found that overall, while the current premises layout was in place, it was likely that peer to peer safeguarding incidents would continue to occur.

In addition, a safeguarding incident in July 2025 resulted in further poor relationships between residents and their neighbours. This led to concerns that the environment and location of the designated centre, was not meeting the needs of one resident. The provider had started the process of completing a disability assessment support application for the resident however, this was at the very initial stages, as potential assisted decision making supports, had yet to be reviewed.

On a walk-around of the internal and external areas of the centre, the inspector observed that the designated centre was in poor state of upkeep and repair. Since the last inspection, works that had been identified to provide a homely environment and to minimise the risk of spread of infectious decease had not been completed. This is discussed further under Regulation 27.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had failed to ensure that the infection prevention and control (IPC) measures in place in the centre, were effective at all times.

While there had been a provider-led infection prevention and control audit carried out in April 2025 and local health and safety and infection, prevention and control (IPC) audits carried out on a monthly basis, they had not been effective in ensuring quality improvements. One monthly IPC audit consistently identified, (for the past nine months), that the centre was in poor upkeep and repair and could not be

cleaned effectively because of this. The audit had not included a response, action plan or timeline to address the issue.

During the last inspection both areas of the premises, (upstairs and downstairs apartments), were identified as being in poor upkeep and repair. On the day of this inspection, the inspector observed that minimum work had been completed and in some areas, the state of repair had declined further.

For example, the inspector observed rust around handrails in a bathroom, stains on the bath, mould and broken tiles, as well as broken sealant and grout surrounding the shower. The staircase and walls was observed to have a lot of chipped paint. A number of the doors and door frames in the downstairs section of the house were observed to appear in a poor state of repair with chipped paint and holes in some. There was dirt and debris observed to the sides and behind the washing machine and clothes dryer. The kitchen floor was cracked and stained in areas and the majority of the kitchen cupboards required upkeep. Walls in the kitchen were stained and marked.

This meant that areas of both apartments, such as kitchens, bathrooms and living areas could not be cleaned effectively which in turn impacted on the implementation of good infection control practices. As there had been further decline to the state of repair since the last inspection, this meant that there was a greater IPC risks presenting.

Judgment: Not compliant

Regulation 28: Fire precautions

Since the last inspection, there had been improvements to the centre's fire safety management systems in place.

The centre's gas boiler was serviced in March 2025 and an appropriate certificate was in place to demonstrate the details of the service. The person in charge had developed and implemented a monitoring system so that the boiler service was carried out in a timely manner going forward.

In addition, there had been shared learning and improvements to service records completed by the external fire safety company. This meant that the service of fire equipment now included appropriate certificates and labels and provided clarity, transparency and assurances of the work completed and the safety standard of the equipment.

Staff had been provided with suitable training in fire prevention and emergency procedures, building layout and escape routes and overall, arrangements were in place for ensuring residents were aware of the evacuation procedure to follow.

There was an up-to-date evacuation plan in place. Both residents had personal emergency evacuation plans in place and these were reviewed on a regular basis. Fire drills were being completed by staff and residents regularly, and records demonstrated that they could safely evacuate residents under day and night time circumstances.

The exit doors were easily opened to aid a prompt evacuation, and the person in charge had implemented additional checks to ensure that fire doors closed properly when the fire alarm activated.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that for the most part, there were safe practices in relation to the ordering, receipt and storage of medicines. The provider had appropriate lockable storage in place in the designated centre for medicinal products and a review of medicine administration records indicated that medicines were administered as prescribed.

The staff member who showed the inspector the resident medical press was knowledgeable on medicine management procedures, and on the reasons medicines were prescribed. They were competent in the administration of medicines and were in receipt of training and ongoing education in relation to medicine management.

All medicine errors and incidents were recorded and reported. Where a resident refused their medication this was recorded and reported to the senior nurse manager on call. On review of one resident's records, the inspector saw that they had refused their medication thirteen times in one month. This included medication to support their mental health. While this had been reported, there was no information to demonstrate that the refusals had been analysed or further discussed in effort to try mitigate the risk of recurrence.

Medicine management was audited regularly in an effort to provide appropriate oversight over the centre's medicine management. However, the inspector found that not all audits were effective. In the case of one resident's medication, the inspector saw that where it was out of date, it had not been identified on the audit. In addition, the dates on a new bottle of the same type of medicine had not been recorded correctly. For example the inspector observed dates on a bottle of liquid medicine and a tube of cream that were out of date but still in use. This meant that there was a potential risk to resident's health should they continue to consume the medicine or use the cream. On the day of the inspection, the staff removed both items from the medication cupboard.

Residents had been assessed to manage their own medicines. Outcomes from these assessments were used to inform residents' individual plans on medicine

management. Neither of the residents were self administering medicines on the day of inspection.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had failed to ensure that all residents were safe at all times and protected from abuse.

Since the last inspection there had been twelve further safeguarding incidents in the designated centre, five of which occurred during October to December 2025. Most of the incidents occurring in the centre related to negative peer to peer interactions and the impact they had on each of the residents. In addition, there had been alleged safeguarding incidents relating to staff and neighbours.

To support the protection of residents and try reduce the risk of peer to peer safeguarding incident, residents were provided with safety plans, positive behaviour support plans and the use of restrictive practices. There was a lot of guidance in place for staff so that they could support residents manage their behaviour, however, due to the current staffing arrangements, poor continuity of care alongside poor induction practices, the effectiveness of the various support plans could not be assured.

The previous inspection had identified that the layout of the centre was not conducive to an environment that meet the needs of residents or was likely to see a reduction in safeguarding incidents. Loud vocalisations, banging on walls and doors was impacting negatively on residents. The noise levels were impacting on their sleep, mood and ability to enjoy a quiet time in their home. Complaints had been made by both residents who noted their upset about the incidents.

Complaints had also been made by neighbours regarding the noise levels. This was resulting in a negative lived experience for residents in their house as well as in their local estate. The inspector was advised on the day, that the neighbours no longer spoke or engaged with the residents.

On the day of the inspection, the inspector met and spoke with both residents. One resident expressed their upset at the noise levels in the house. They told the inspector that they cried when they heard the banging noises. They said that they could not sleep when there was noise coming from the other apartment during the night time. The resident started to cry as they relayed their views to the inspector.

The inspector also spoke to a resident's family members. They expressed their unhappiness at the staffing arrangements in place in the centre. They told the inspector that they had found since June 2025 that a lot of the staff supporting their family member were agency or relief staff. They felt that unfamiliar staff were not aware of their family member’s needs. The said there had been more throwing

incidents during recent times which has resulted in breakage of the resident's own possessions and in particular, the resident' television. The said a lot of staff did not understand what the resident was communicating to them which would often lead to the resident becoming frustrated, upset, shouting and banging.

Overall, the inspector found that the timeliness of plans to mitigate the risk of ongoing safeguarding incidents was not satisfactory and was having negative outcomes for residents in the home and community. As the current potential plans were reliant on external factors and funding, there was a high likelihood that the safeguarding incident would continue in the centre.

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
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Newbrook OSV-0002344

Inspection ID: MON-0048079

Date of inspection: 21/01/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Specific recruitment campaign for the Designated centre was launched on the 11/02/2026. • The provider with the support from Human Resource recruitment team will continue to recruit social care workers and assign them to the designated centre. (31/08/2026) • Two relief staff are currently assigned to the Designated centre to cover vacancies and provide consistency of care for residents on 30/6/2025. • Service manager liaised with relief staff coordinator to request additional relief staff to be assigned to the center 19/02/2026. • Full review of staff allocation practices including the use of relief and agency staff will be carried out to ensure equal allocation of staff to each resident. This will ensure that each resident has equal allocation of drivers also. (07/03/2026) • Working roster reviewed to include staff full name, employee number and grade. (01/02/2026) • Monthly review of working rosters to ensure required staff details are present. If consistent over a six month period this check can be discontinued. Results for review by the Service improvement team (SIT). (31/08/2026) • The number of staff who can administer medication has increased. The two-relief staff assigned to the designated centre are trained in safe administration of medication on 29/9/25 and 28/11/25. One other relief staff completed this training on 30/1/26. In addition, one core staff member is booked in for training on 23rd and 24th March 2026. • SAM training levels will be monitored by the PIC. A decrease in the number of staff with this training will be discussed with the Service Manager and an action plan will be put in place. • A roster review is scheduled for the 18th of March, to ensure there is protect time for a staff to complete a detailed induction and complete FEDS training if required before the shift commenced (18/03/2026) • A review of the "Essential Guide to the Designated Centre" was completed on 12/2/26. • A detailed induction checklist was created to ensure all staff are informed of the information required to safely and proactively support both residents on 12/2/26.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Disability Supports Application Management Tool (DSAMT) completed and submitted to the HSE to seek a bespoke service to meet the resident needs from external providers (06/02/2026)
• A service improvement team has been convened to ensure regulatory compliance, quality improvement and service enhancement of Newbrook Avenue. The first meeting of this team took place on 23/02/2026.
• All actions set out to address compliance, quality improvement and service enhancement will be monitored by the service improvement team on a monthly basis. Where actions do not meet the target dates or where they do not result in improvements they will be re-evaluated and altered as required. (31/08/2026)
• Monthly data sheets will be reviewed at each service improvement team meeting and will be evaluated for improvements and potential trends. Where improvement is not achieved, actions under will be devised to address same. (31/08/2026)
• Key audits (i.e. 6 monthly audits) in the approved centre will be presented to the service improvement team. Any non-compliances and associated action plans will be reviewed to ensure service improvement is implemented and sustained. (31/08/2026)

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The Person in Charge will conduct a full review of the five complaints. This review will include steps taken to resolve the complaints and include a documented consultation with the residents involve outlining their response. (10/03/2026)
• If necessary, the complaints will be escalated to the provider in line with the provider's complaints procedures (10/03/2026)
• The staff team will complete face to face training on the complaint procedure and open disclosure (04/03/2026)

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• ICM scheduled to conduct a multi – disciplinary review of resident's preferences regarding day service attendance and engagement in community activities (24/02/2026)
• All refusals to attend day service or to engage with activities are being tracked to ensure effective review of the resident positive behaviours support plan. (03/02/26)
• Positive behaviours support plan is currently under a full restructure review to reflect changes in patterns of withdrawal and behaviours. Review meetings were held on 28/1/26 and 16/2/26. Next review meeting scheduled for 27/02/26. PBSP Restructure completed by 15/04/2026.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: • Disability Supports Application Management Tool (DSAMT) completed and submitted to the HSE for additional supports to meet one resident needs (06/02/2026) • A potential long-term solution is the construction of a stand-alone apartment in the grounds of designated centre. However, conservative estimates for completion of this project would be February 2028. The provider has submitted an application for CAS funding to Dublin City Council, and this is currently at stage 3 – no date has been provided for an outcome, but it may take up to six months (31/08/26). • The Head of Technical Services and the Service Manager will complete a walk-through of the Designated Centre to develop an updated inventory of all works required to bring the premises back into compliance. This review will be completed by 26.02.2026. • A comprehensive work plan will be developed from the updated inventory (06.03.2026) • All identified premises works will be completed by the 30.06.2026 - monthly progress reports will be presented to the Service Improvement Team. • Service Improvement meeting with the multi disciplinary team (MDT) commenced on the 23/02/2026	
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • The Head of Technical Services and the Service Manager will complete a walk-through of the Designated Centre to develop an updated inventory of all works required to bring the premises back into compliance with protection against infection. This review will be completed by 26.02.2026. • A comprehensive work plan will be developed from the updated inventory (06.03.2026) • All identified premises works will be completed by the 30.06.2026 - monthly progress reports will be presented to the Service Improvement Team. • Identified work to ensure the environment is homely and to reduce the risk of spread of infection will be completed by the end of the 2nd Quarter in 2026. (30/06/2026) • Service improvement meeting with the MDT commenced on the 23/02/2026.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • The residents Medication Refusal Protocol and Medication support plan was reviewed to ensure effectiveness on 05/02/26. • Resident's psychiatrist is notified monthly of refusal of medication, Records available for review. (01/02/2026) • Meeting schedule with psychiatrist and resident on 23/02/2026. • ICM scheduled to conduct a multi – disciplinary review of resident's refusal of medication. (24/02/2026) • The person in charge completed a full inventory of the medication press to ensure all medication was fit for use on 05/02/26. • Out of date medicines were removed on the day of inspection (21/01/2026)	

• Auditing and disposal of medication policy was reviewed and discussed at staff meeting on the 04/02/2026 • Audit has been updated to include date of disposal on medicines that must be disposed of within a defined timeframe from opening. (05/02/2026) • PIC will review the new audit monthly to ensure that it effective for a period of 6 months. (31/08/2026)

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • Disability Supports Application Management Tool (DSAMT) completed and submitted to the HSE for additional supports to meet one resident needs (06/02/2026) • A potential long-term solution is the construction of a stand-alone apartment in the grounds of designated centre. However, conservative estimates for completion of this project would be Feb 2028. The provider has submitted an application for CAS funding to Dublin City Council, and this is currently at stage 3 – no date has been provided for an outcome but it may take up to six months (31/08/26). • Safeguarding plans are in place and are reviewed every quarter. • Substantial doorstops are being installed on all doors at the property to reduce the noise from doors being slammed closed/against the wall. (27/02/26) • Service Improvement meeting commenced on the 23/02/2026.

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Substantially Compliant	Yellow	15/04/2026
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	15/04/2026
Regulation 15(1)	The registered provider shall ensure that the number,	Not Compliant	Orange	31/08/2026

	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.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	19/02/2026
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	01/02/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/08/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the	Not Compliant	Orange	30/06/2026

	designated centre are of sound construction and kept in a good state of repair externally and internally.			
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	31/08/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/08/2026
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare	Not Compliant	Orange	30/06/2026

	associated infections published by the Authority.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	05/02/2026
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant	Substantially Compliant	Yellow	05/02/2026

	national legislation or guidance.			
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	10/03/2026
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	10/03/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	10/03/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/08/2026