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:	Garvagh House
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	07 April 2026
Centre ID:	OSV-0002348
Fieldwork ID:	MON-0041354

About the designated centre

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

Garvagh House is a residential service for five adults with intellectual and physical disabilities. The centre is operated by St Michael's House. The centre comprises a large detached house located in North County Dublin. There are four resident bedrooms, one staff sleepover room, a sensory room, quiet room, sitting room and kitchen/dining room, as well as a self-contained apartment attached to the main building. The centre is within walking distance of public transport and a range of local amenities which residents frequently use. There is a well-proportioned garden to the rear of the centre for residents to enjoy. The centre is managed by a person in charge with support from a deputy manager, and they report to a service manager. The staff team consists of social care and direct support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 7 April 2026	09:45hrs to 18:15hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This announced inspection was carried out as part of regulatory monitoring of the centre and to help inform a decision on the provider's application to renew the registration of the centre. The inspector used observations, conversations and engagements with residents, their representatives and staff, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents in the centre.

Previous inspections of the centre had found ongoing and longstanding incompatibility issues between residents that were adversely impacting on their safety and wellbeing. In 2025, the provider was required to attend an escalation meeting with the Office of the Chief Inspector of Social Services (Chief Inspector) in relation to their failure to operate the centre in compliance with regulation. The provider submitted a compliance plan that outlined the actions they would take and the time frames by which they intended to come into compliance.

However, this inspection found the provider had not achieved the necessary actions to come into compliance under all of the regulations inspected, and particularly in relation to the safeguarding of residents and protection of their rights. The inspector found that the centre remained unsuitable to meet the needs of the residents which was contributing to persistent safeguarding concerns and negatively impacted on their quality of life.

The centre comprises a large two-storey detached house and a stand alone apartment in a busy Dublin suburb. The centre is close to many amenities and services, including shops, bars, parks, and the beach. There is also a vehicle available for residents to access their wider community. There are individual bedrooms, shared communal spaces including an open-plan kitchen and dining room, two sensory rooms, a utility room, bathrooms, and a staff office. One resident resided in a small self-contained apartment connected to the house. The apartment contains a bedroom with an en-suite bathroom, and a small open-plan kitchen and living area. There are nice gardens at the rear of the house for residents to use.

The inspector observed that the premises were warm, bright, comfortable, and clean. The residents' bedrooms were personalised to their tastes. One resident's bedroom had been recently redecorated, and it was seen to reflect their personality and interests. There were pictures of residents in the communal areas, which added to the homeliness of the centre. In the kitchen and dining room, notice boards displayed visual information on the HIQA inspection, making complaints, the menu and staff rota. A small sitting room had also been converted into a sensory room and space for residents' visitors. It was nicely decorated and provided an inviting space for residents to use. Specialised equipment was available to residents, such as mobility aids, and it appeared to be in good working order.

Notwithstanding the description of the building outlined above, the premises was not meeting the assessed needs of all residents, and this was adversely impacting on their quality of life. The inspector reviewed reports from members of the provider's multidisciplinary team which recommended that some residents required more space. These reports outlined that some residents required individualised living arrangements and to move out of the centre, and they noted that some residents expressed distress and upset due to their living arrangements.

The centre accommodated five residents. The inspector had the opportunity to meet four residents. One resident was not present as they were staying with their family on the day of the inspection. Three residents attended day services and the inspector met them in the morning and in the afternoon when they returned. Another resident was support with their social and leisure activities by staff in the centre. On the day of the inspection, they went shopping and had their lunch out. In the evening, some residents relaxed in the centre by using their smart devices and watering flowers in the garden, while others went with staff for a walk and dinner in a local restaurant.

Three residents did not communicate verbally, and used multimodal means of communication, such as vocalisations, gestures, objects of reference, manual signs and body language to communicate. They did not express their views to the inspector, but engaged through eye contact, taking the inspector's hand to hold, manual signs, and facial expressions, such as smiling and laughing.

One resident verbally communicated. They showed the inspector around their living space and some of their personal belongings. They spoke about the activities that they enjoyed, including listening to music, the cinema, using smart devices, shopping and social events. The resident told the inspector that they did not like living in the centre, and did not like the loud noises made from other residents.

The inspector observed that staff demonstrated a good understanding of the residents' communication means. For example, they understood manual signs used by residents, and were able to describe to the inspector how visual aids were used to help residents' make choices.

The inspector also observed staff kindly engaging with residents, and residents appeared comfortable and familiar with staff supporting them. For example, staff provided gentle reassurances to residents, spoke warmly with them, promptly responded to their requests, and residents and staff laughed together.

The inspector had the opportunity to speak with one resident's family member when they were visiting their loved one. The family member praised the staff team, describing them as 'lovely, caring and welcoming'. They said that staff followed the resident's care plans, understood their communication means, and supported the resident to make choices. They also complimented the person in charge for bringing improvements to the centre to make it more person-centred. The family member told the inspector about some of the positive aspects of the resident's life, such as attending a new day service that was specific to their needs and providing them with more social opportunities like using public transport and going on day trips.

The family member also expressed concern about the resident's safety and wellbeing in the centre due to the longstanding incompatibility issues that were having a negative impact on the resident. For example, the resident was sensitive to noise and became upset and distressed when other residents made loud noises. When the resident became upset, they could escalate and engage in self-injurious behaviours. The family member told the inspector that it was very upsetting for them to see their loved one distressed. The family member visited the centre very often, and said that they frequently observed these incidents. The family member also told the inspector that the resident's access to their home was restricted at times when other residents were present. During the inspection, the family member raised a formal complaint with the management team on their loved one's behalf about the ongoing incompatibility issues and risks to their safety. The inspector also read similar concerns about incompatibility issues raised by family members in the recent annual review of the centre.

Staff told the inspector about their concerns about the ongoing incompatibility issues on residents' safety and wellbeing. The inspector did not observe any safeguarding incidents during the inspection; however, one resident did retreat into their bathroom in the afternoon and spent a considerable time there when another resident was due to return to the centre. The resident viewed the bathroom as a safer space away from other residents. Residents' safety and protection is discussed further in the report and in particular under Regulation: 8 Protection.

In addition, the inspector observed restrictive practices, including environmental and rights restrictions. The rationale for the restrictions, for the safety and wellbeing of residents, was clear and the person in charge demonstrated a commitment to reducing the use of restrictions. However, the inspector found that the provider's oversight of the restrictions required improvement.

The inspector also observed good fire safety precautions, such as fire detection and fighting equipment throughout the centre. The premises, restrictive practices, and fire safety are discussed further in the quality and safety section of the report.

The inspector found that the management team and staff working in the centre were endeavouring to provide a quality and safe service for residents. However, while there was some good practice observed in the centre, the provider had failed to resolve the longstanding incompatibility issues, which were adversely impacting on residents' wellbeing, quality of life, and right to feel safe and at peace in their home.

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

Capacity and capability

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 good quality and safe service was being provided in the centre. This inspection was carried out as part of the provider's application to renew the registration of the centre, and to monitor compliance with the regulations, and the provider's delivery of safe and effective care and support that protected residents from abuse.

While improvements were found under some regulations, such as Regulation 15: Staffing, and the inspector saw that the staff and management team were striving to meet residents' care and support needs, the provider had failed to come into compliance since the previous inspection under key regulations, including Regulation 8: Protection. These issues will be discussed further under the relevant regulations later in this report.

There was a clearly defined management structure with lines of authority and responsibility. The structure included the person in charge, two deputy managers, a service manager and a director of service. There were good arrangements for the management team to communicate and escalate information, such as formal meetings and sharing of governance reports. The team demonstrated a good understanding of the residents' needs and expressed concerns about the current service provided to them. These concerns are noted further in the report.

There were oversight and monitoring systems in place at local and provider level. Annual reviews (which consulted with residents and their representatives) and six-monthly unannounced visit reports, and a range of audits on areas were carried out to identify areas for improvement. As part of the recent annual review, residents' representatives complimented the staff team and the standard of care they provided to residents, but some also raised concern about how their loved ones were negatively impacted due to the behaviours of other residents.

The provider had an established complaints procedure, which residents and their representatives had availed of. However, it was limited in effectiveness as complaints remained open due to the provider's failure to resolve the incompatibility issues.

The staffing arrangements had improved since the last inspection and the inspector found them to be in line with residents' needs and ensuring consistency of care. There were some staff vacancies, but they were well managed to reduce any potential adverse impact on residents. The inspector review three staff files (as detailed in Schedule 2), and found that they contained the necessary information. There were also good arrangements to ensure that staff were in receipt of regular support and supervision, and completed relevant training to inform their delivery of effective care and support to residents.

The inspector found that staff spoken with had a rich understanding of residents' personalities, interests, needs and communication means. They spoke warmly about residents, but also expressed concern for residents' wellbeing and the consequences of living in a home where they were regularly exposed to behaviours that upset them. The inspector also read similar concerns recorded in the 2026 staff team

meeting minutes. The March 2026 minutes, which was attended by members of the provider's multidisciplinary team, noted the continued negative impact on some residents from living in the centre and that a move would be in their best interests.

The provider's application to renew the registration of the centre included the required prescribed information, such as a statement of purpose and residents' guide.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider submitted an application to renew the registration of the centre. The application contained the required information set out under this regulation and the related schedules. For example, the statement of purpose, residents' guide and a contract of insurance.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. The person in charge was based in the centre. They were found to be suitably skilled and experienced for the role, and possessed relevant qualifications in social studies and management.

The person in charge had an excellent understanding of the residents' individual personalities and needs, and was endeavouring to ensure that they received a good quality and safety service.

Judgment: Compliant

Regulation 15: Staffing

The staff skill-mix comprised the person in charge, two deputy managers, social care workers, and direct support workers. The management team was satisfied that the skill-mix and complement was appropriate to the current needs of the residents. They told the inspector that the staff knew the residents well and provided good care and support.

Since the previous inspection, the provider had filled most of the staff vacancies. At the time of this inspection, there were 2.2 of 13.7 whole-time equivalent vacancies, and one post was due to be filled in the coming weeks. Regular relief staff and staff

working additional hours covered the vacant shifts. The improvements in the staffing arrangements were contributing to better consistency of care for residents, and staff and the management team told the inspector that this was having a positive effect. For example, incidents had reduced as residents were more familiar with staff supporting them, who in turn were well informed on the residents' needs.

The person in charge maintained planned and actual staff rotas. The inspector viewed the February, March and April 2026 planned and actual rotas and found that they clearly showed the names of the staff and the hours they worked.

The inspector reviewed three staff Schedule 2 files. The files were well maintained, and contained the necessary information, such as vetting disclosures, evidence of qualifications and identity, and references.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents. The training included safeguarding of residents, first aid, manual handling, supporting residents with modified diets, infection prevention and control (IPC), positive behaviour support, administration of medication and fire safety. The inspector reviewed the recent training audit report with the person in charge, it showed that most staff were up to date with their training requirements, and any due training was scheduled. Staff had also attended additional bespoke training sessions with members of the provider's multidisciplinary team, such as on trauma-informed care and person-centred planning.

The person in charge ensured that staff were supported and supervised in their roles. The person in charge was based in the centre to provide informal supervision, and formal supervision was scheduled to take place every three months as per the provider's policy. The inspector reviewed three staff member's supervision records, and found that they had received regular formal supervision. Staff spoken with told the inspector that they were very satisfied with the support they received from the management team, and said that they could easily raise concerns.

Judgment: Compliant

Regulation 22: Insurance

The provider had effected a contract of insurance against injury to residents and other risks in the centre including damage to property.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not ensured that the centre was adequately resourced to ensure the delivery of safe and consistent care and support to residents.

During this inspection, the inspector was told and read that the provider did not have the means to resolve the longstanding incompatibility issues and had engaged with their funder to explore alternative service options that could better meet the needs of some residents. However, there were no confirmed plans for any resident to move to more appropriate homes, and therefore, residents remained at risk of harm in the centre.

Improvements had been made since the previous inspection in relation to some resources, such as the staffing arrangements, and it was clear that the management team and staff were committed to advocating for residents' needs to be met. However, the provider had not ensured that the centre was appropriate to residents' needs or that they were safe and protected from abuse and distress. Following the previous inspection, the provider had attended an escalation meeting which outlined the possible consequences of continued non-compliance. The provider submitted a compliance plan with actions to come into compliance. The provider had failed to resolve all of the areas of non-compliance, including in relation to its measures to protect resident from abuse.

The ongoing incompatibility issues and adverse impact on residents' quality of life was reviewed and reported on in the provider's audits, governance reports, and minutes of the service improvement team's meetings that included members of the senior management team and multidisciplinary team. The minutes of the 2026 service improvement team meetings noted that the provider did not have the means to meet all residents' needs, and that living in the centre was having an adverse impact on them. The provider had recently engaged with their funder to explore some residents moving to more suitable service providers; however, there was no confirmation or time frame for any moves. This meant that despite the provider identifying the issue, staff at a local level advocating on behalf of the residents, residents and families expressing concerns regarding the negative impact this was having on them the residents continued to live in an environment that impacted negatively on their safety and welfare.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1. It was last reviewed in January 2026, and was available in the centre. Information in the statement of purpose was in an easy-to-read format using pictures to make it more accessible to residents and their representatives.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had implemented a complaints procedure for residents, which was underpinned by a written policy. It outlined the processes for managing complaints, the relevant persons' roles and responsibilities, and information for residents on accessing advocacy services. The procedure had been prepared in an easy-to-read format which was readily available in the centre, and the management team support residents and their representatives to utilise it. However, the procedure was not fully effective as complaints raised by residents and their representatives had not been resolved.

The inspector reviewed some of the recent complaints. A complaint raised in October 2025 had been managed to the satisfaction of the complainants. However, a complaint raised in July 2025 regarding the peer-to-peer concerns remained opened as it could not be resolved until the incompatibility issues were resolved. During the inspection, the person in charge supported a resident's representative to raise another complaint related to the ongoing incompatibility issues and the impact on their loved one.

The inspector found that while the provider has a process in place to make complaints, the complaints were not addressed to the satisfaction of the residents and no timeframe for addressing the matter was in place.

Judgment: Not compliant

Quality and safety

This section of the report focuses on regulations related to the quality and safety of the care and support provided to residents in the centre and how it effected residents' safety and wellbeing.

This inspection found that residents' assessed needs were not being fully met in the centre and that the provider had not resolved the longstanding incompatibility issues. These issues were having an adverse impact on their safety, wellbeing and

overall quality of life. For example, the inspector was told and read how residents had experienced distress, upset and harm, and were displaying trauma responsive behaviours as a result of being frequently and continually exposed to the behaviours of other residents.

In advance of the inspection, questionnaires were sent for residents to complete on what it is like to live in the centre. Three questionnaires were completed. Overall, the residents provided good feedback, and indicated that they were satisfied with the staffing arrangements and the care they provided. However, one resident said that access to their money could be better, one resident said that they did not feel fully safe, and three residents said that they do not get along with everyone they live with.

The inspector found that safeguarding incidents had been reported, and safeguarding plans were in place. However, the safeguarding arrangements were not effective, and this was seen through recurring incidents and ongoing written and verbal concerns expressed by staff, the management team, the multidisciplinary team, residents and their representatives about residents' safety and quality of life.

The person in charge had ensured that residents' needs were assessed. The assessments of residents' needs were reviewed on an ongoing basis and were used to inform written care plans.

The management team had implemented arrangements for residents to be consulted with and express their views.

The inspector found that residents received good support to manage their behaviours. However, the effectiveness of the support was limited due to the fundamental issue of residents' incompatibility to live together, which was an ongoing issue in the centre.

The local management team were committed to reducing the use of restrictive practices in the centre, and had ensured that residents were consulted with about their use. However, improvements were required to ensure that all restrictions were being applied in line with evidence based best practice; as not all restrictions were been reviewed by the provider's oversight group. Additionally, the inspector found that not all residents had access to their own monies. These matters had also been identified in the previous inspection of the centre.

The premises comprises a large two-storey detached house. The house comprises individual resident bedrooms, a sitting room, open-plan kitchen and dining room, utility facilities, two sensory rooms, a staff office, and rear garden. There was also an attached self-contained apartment for one resident. The premises was observed to be clean, and parts of it had been renovated and redecorated since the previous inspection. However, the environment was not fully suitable for all residents. For example, some residents required a quiet and peaceful home; however, there was frequent loud noises and incidents which affected residents' wellbeing.

Regulation 17: Premises

The premises comprised a large two-storey detached house with a front driveway and rear gardens. Within the premises, there are individual residents' bedrooms, an open-plan kitchen and dining room, sitting rooms, a utility room, two sensory rooms, bathrooms, a staff room, and a small-apartment attached to the main building that one resident lived in. Residents' bedrooms were personalised to their tastes and provided sufficient space for their belongings. Since the previous inspection, parts of the house had been repainted and the small sitting room had been converted into an additional sensory room for residents to use. Overall, the house was bright, comfortable and appeared to be clean.

However, the premises was not suitable for all residents and their needs. Some residents required a quiet and peaceful environments and individualised living arrangements that the centre did not provide. This assessment had been determined by members of the provider's multidisciplinary and management team. The impact of this is discussed and actioned under Regulation 5: Individualised Assessment and Personal Plan and Regulation 8: Protection.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had ensured that a residents' guide was available to residents in the centre It contained information on the services and facilities provided in the centre, visiting arrangements, complaints, accessing inspection reports, and residents' involvement in the running of the centre. It was written in an easy-to-read format using pictures to make it more accessible to residents.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had implemented good fire safety precautions in the centre. There was fire detection and fighting equipment, and emergency lights throughout the house. There were arrangements for the equipment to be maintained in good working order. The servicing of the fire alarms and emergency lights was overdue servicing about approximately four weeks at the time of the inspection. However, the person in charge received confirmation from the provider's fire safety officer before the inspection concluded that the servicing would be completed by the end of the week. The inspector released the fire doors, including the utility room, sitting room, and bedroom doors, and found that they all closed fully except for one. The

person in charge also reported this matter to the provider's fire safety officer during the inspection for rectification.

Staff in the centre had completed fire safety training, and completed daily, monthly and quarterly fire safety checks. There was an evacuation plan for the centre and individual evacuation plans for the residents. Staff were found to have a good understanding of the plans. The individual plans were up to date and outlined the supports residents required. Fire drills were carried out to test the effectiveness of the fire plans. Residents were reminded about fire safety during their house meetings.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of three residents' assessments and care plans, including their plans on health, communication, behaviour, social goals, intimate care, and safety. The plans were up to date and readily available to guide staff practice. They were written in a person-centred way and described the residents' individual personalities and needs. Some of the plans had also been prepared in an easy-to-read format to make them more accessible. Residents' assessments and plans reflected input from a wide range of multidisciplinary team services.

The provider had not ensured that the centre was suitable or that appropriate arrangements were in place to meet the assessed needs of each resident. This judgment was also found during previous inspections of the centre.

The provider had assessed residents' needs and determined that they were not all compatible to live together due to their complex individual needs, and that the environment was not suitable. The incompatibility issues were having an adverse impact on some residents' lived experience. Concerns about residents' incompatibility were highlighted in multiple sources, including residents' care plans, risk assessments, safeguarding reports and plans, complaints, multidisciplinary team records, and audits such as the annual review and unannounced visit reports.

The provider had made efforts to mitigate this longstanding concern, and following the previous inspection had committed to ensuring that arrangements were put in place to meet the needs of each resident and that the centre was suitable for them to live in by 31 March 2025. However, the provider failed to meet this time frame, and while efforts were ongoing to meet residents' needs, there was no confirmed plans as to when the provider would be successful.

Judgment: Not compliant

Regulation 6: Health care

Residents' health care needs had been assessed, and were under regular review. The inspector reviewed two residents' health care records, and found that they were in receipt of appropriate care and services in respect of their assessed needs.

Health care plans were available to guide staff on the care and support residents required. Residents' health care records showed that they were supported to avail of a range of multidisciplinary team services, including internal and external services, such as physiotherapy, occupational therapy, dentists, chiropody, dietitians, psychology, psychiatry, nursing, and their own general practitioners (GP).

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had implemented systems to support residents to manage their behaviours of concern. The inspector reviewed three residents' behaviour support plans. The plans were up to date, had been prepared with input from the provider's multidisciplinary team, and were available to guide staff practice. However, the effectiveness of the interventions was limited due to the fundamental issue of the centre not been suitable to meet all residents' needs, and this was contributing to some residents' behaviours of concern.

There was a significant amount of restrictive practices implemented in the centre. The restrictions included night checks of some residents, locked doors and windows, and restricted access at times to smart devices and cutlery. It was clear that the management team were committed to reducing the use of restrictive practices; for example, restrictions were reviewed by the local management team on a regular basis and the use of certain restrictions had been removed since the last inspection. Social stories using pictures had also been prepared to help residents understand the rationale for the restrictions and to help inform their decision to consent to their use.

However, at provider level, there was inadequate oversight to monitor the use of restrictions. For example, the provider's approval group did not review or assess the use of all restrictions, such as restrictions on access to smart devices and night checks. These restrictions could pose a risk to residents' privacy and rights, and required monitoring from the provider to ensure that they were in line with policy and evidence based practices. This gap in the provider's oversight had been highlighted in the previous inspection, and the provider had failed to address it.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had implemented systems to safeguard residents from abuse, which were underpinned by a written policy. However, these systems were not fully effective, and the ongoing incompatibility issues were continuing to adversely impact on residents' wellbeing and quality of life.

Since the previous inspection in April 2025, 41 notifications of allegation of abuse were reported to the Chief Inspector. Thirty-eight notifications related to peer-to-peer issues; one alleged physical abuse and 37 alleged psychological abuse. The inspector reviewed a sample of the incidents with the person in charge, and found that they had been appropriately reported in line with the national safeguarding policy. Safeguarding plans were in place; however, they were not effective as the incompatibility of residents, which was contributing to the incidents had not been resolved.

Some residents expressed concern to the inspector about their their living arrangements, and a family member told the inspector about their worry for their loved one due to their continued exposure to other resident's behaviours that caused them upset and distress. Staff and the management team also told the inspector about their concerns for residents' safety and wellbeing, and how some residents were anxious and fearful at times.

Additionally, some residents were displaying trauma responsive behaviours, such as retreating to and sleeping on a bathroom floor, due to continued exposure to triggers that caused them distress, fear and upset. These concerns were also reported throughout meeting minutes, reports, residents' assessments and plans, audits, and complaints, and had been escalated to the provider's funder.

Judgment: Not compliant

Regulation 9: Residents' rights

There were arrangements to promote the rights of residents in the centre; however, the ongoing incompatibility issues impinged on some residents having free access to all parts of their homes at all times, and not all residents had access to their finances. These issues were also identified during the previous inspection of the centre, and the provider had failed to resolve them.

Some residents were distressed when other residents made loud noises, and this impacted on how freely they could use their home. For example, during loud vocalisations, some residents chose to retreat into other rooms to minimise the impact on them. Some residents expressed their unhappiness to the inspector about

living with other residents, and as noted throughout this report, the provider had failed to ensure that residents' right to feel safe in their home was upheld.

In addition, three residents did not have full access to their own finances. Staff told the inspector how this impacted on residents; for example, residents could not make spontaneous purchases and in some cases be involved in the purchasing of items for them. The provider's safeguarding committee were taking some action such as engaging with residents' representatives; however, these actions had not yet been successful in ensuring that residents could access their own money.

The inspector found that residents attended house meetings where they planned their main activities, reviewed goals, and discussed any concerns they may have. The inspector reviewed a sample of the meeting minutes, which noted discussions on goals such as attending new day services and attending festivals and events, fire safety, restrictive practices, and residents' happiness in their home. The minutes of the 2025 meetings, noted that one resident said that they would like to change who they lived with, the noise and shouting 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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Garvagh House OSV-0002348

Inspection ID: MON-0041354

Date of inspection: 07/04/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • One resident is currently undergoing placement consultations with two external providers. Assessments with both providers will be completed by 19th June 2026, with a final placement recommendation and next steps agreed thereafter to support an appropriate transition plan. • Agreement has been reached with the providers funder to commence consultations with external providers for the second resident. The external referrals will be completed and returned to the providers funder by the 29th of May 2026. • SMH have acquired a property that can be reconfigured to create an individualised placement for two residents. The Board of SMH have committed to funding this project at a meeting held on the 28th of April 2026. Scoping of the works required to reconfigure this property is currently underway with a plan to have completed these and created a project plan by the 26th of June 2026. This creates a viable alternative for the two residents in Garvagh should the referrals to external providers not result in a successful placement.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • One resident is currently undergoing placement consultations with two external providers. Assessments with both providers will be completed by 19th June 2026, with a final placement recommendation and next steps agreed thereafter to support an appropriate transition plan. • Agreement has been reached with the providers funder to commence consultations with external providers for the second resident. The external referrals will be completed and returned to the providers funder by the 29th of May 2026. • SMH have acquired a property that can be reconfigured to create an individualised	

placement for two residents. The Board of SMH have committed to funding this project at a meeting held on the 28th of April 2026. Scoping of the works required to reconfigure this property is currently underway with a plan to have completed these and created a project plan by the 26th of June 2026. This creates a viable alternative for the two residents in Garvagh should the referrals to external providers not result in a successful placement.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• One resident is currently undergoing placement consultations with two external providers. Assessments with both providers will be completed by 19th June 2026, with a final placement recommendation and next steps agreed thereafter to support an appropriate transition plan.
• Agreement has been reached with the providers funder to commence consultations with external providers for the second resident. The external referrals will be completed and returned to the providers funder by the 29th of May 2026.
• SMH have acquired a property that can be reconfigured to create an individualised placement for two residents. The Board of SMH have committed to funding this project at a meeting held on the 28th of April 2026. Scoping of the works required to reconfigure this property is currently underway with a plan to have completed these and created a project plan by the 26th of June 2026. This creates a viable alternative for the two residents in Garvagh should the referrals to external providers not result in a successful placement.
• The communication assessment waitlist has recently opened. The service user has been highlighted as a priority and will receive the assessment by the 7th of August 2026.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• One resident is currently undergoing placement consultations with two external providers. Assessments with both providers will be completed by 19th June 2026, with a final placement recommendation and next steps agreed thereafter to support an appropriate transition plan.
• Agreement has been reached with the providers funder to commence consultations with external providers for the second resident. The external referrals will be completed and returned to the providers funder by the 29th of May 2026.
• SMH have acquired a property that can be reconfigured to create an individualised placement for two residents. The Board of SMH have committed to funding this project at a meeting held on the 28th of April 2026. Scoping of the works required to reconfigure this property is currently underway with a plan to have completed these and created a project plan by the 26th of June 2026. This creates a viable alternative for the two residents in Garvagh should the referrals to external providers not result in a successful placement.
• The Director of Quality, Safety and Risk in conjunction with the Assisted Decision-

Making Steering Committee, will develop a policy and framework to inform the discussion and use of rights restrictions, ensuring that any recommended restrictions are appropriately assessed, authorised, regularly reviewed, monitored, and reduced where possible, in line with current St. Michael's House policies and process, residents' rights, risk and national policy. This will be completed by the 30th of June 2026.
• The restriction relating to smart devices was removed on the day of inspection. In lieu of the organisational process being put in place, a rights-focused Integrated Co-Ordination Meeting will be arranged to review the ongoing use of night checks for one resident. A member of the Assisted Decision-Making Steering Committee will also attend this meeting. This will be completed by the 5th of June 2026.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• One resident is currently undergoing placement consultations with two external providers. Assessments with both providers will be completed by 19th June 2026, with a final placement recommendation and next steps agreed thereafter to support an appropriate transition plan.
• Agreement has been reached with the providers funder to commence consultations with external providers for the second resident. The external referrals will be completed and returned to the providers funder by the 29th of May 2026.
• SMH have acquired a property that can be reconfigured to create an individualised placement for two residents. The Board of SMH have committed to funding this project at a meeting held on the 28th of April 2026. Scoping of the works required to reconfigure this property is currently underway with a plan to have completed these and created a project plan by the 26th of June 2026. This creates a viable alternative for the two residents in Garvagh should the referrals to external providers not result in a successful placement.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• One resident is currently undergoing placement consultations with two external providers. Assessments with both providers will be completed by 19th June 2026, with a final placement recommendation and next steps agreed thereafter to support an appropriate transition plan.
• Agreement has been reached with the providers funder to commence consultations with external providers for the second resident. The external referrals will be completed and returned to the providers funder by the 29th of May 2026.
• SMH have acquired a property that can be reconfigured to create an individualised placement for two residents. The Board of SMH have committed to funding this project at a meeting held on the 28th of April 2026. Scoping of the works required to reconfigure this property is currently underway with a plan to have completed these and created a project plan by the 26th of June 2026. This creates a viable alternative for the two residents in Garvagh should the referrals to external providers not result in a successful placement.
• An agreement has been reached with two of the resident's families to regularise bank accounts by the 29th of May 2026 which will resolve the restrictions two resident have in relation to access to their finances.

• Agreement has not been reached to regularise the bank accounts for one remaining residents. The Designated Officer escalated this matter on the 8th of May 2026 to HSE Local Safeguarding Team and the Department of Social Welfare. The advice of these teams will be utilised to inform and progress the management of this issue, including consideration of escalation steps where appropriate, which may include notification to An Garda Síochána.
• The Director of Quality, Safety and Risk in conjunction with the Assisted Decision-Making Steering Committee, will develop a policy and framework to inform the discussion and use of rights restrictions, ensuring that any recommended restrictions are appropriately assessed, authorised, regularly reviewed, monitored, and reduced where possible, in line with current St. Michael's House policies and process, residents' rights, risk and national policy. This will be completed by the 30th of June 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 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.	Substantially Compliant	Yellow	26/06/2026
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	26/06/2026
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for	Not Compliant	Orange	26/06/2026

	residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.			
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	26/06/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	07/08/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Yellow	26/06/2026
Regulation 07(4)	The registered provider shall ensure that, where	Not Compliant	Orange	30/06/2026

	restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	26/06/2026
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	26/06/2026
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	30/06/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not	Not Compliant	Orange	30/06/2026

	limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			