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:	Fox's Lane Residential
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	29 January 2026
Centre ID:	OSV-0002366
Fieldwork ID:	MON-0045429

About the designated centre

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

Fox's Lane is a designated centre operated by St Michael's House. The centre is a community based home which provides full-time residential care and support for up to four adults both male and female with varying degrees of intellectual and physical disabilities. The centre consists of a five-bedroom bungalow with two sitting rooms, a kitchen/dining area, shower room and two bathrooms. It is situated in a mature residential cúl-de-sac with coastal views and a variety of local amenities such as shops, churches, restaurants, pubs, beauticians, a medical centre, pharmacies, hairdressers, barbers, banks and local beaches. There is a vehicle to enable residents to access local amenities and leisure facilities in the surrounding areas. Residents in the centre are supported by a staff team comprising of a person in charge and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 29 January 2026	10:00hrs to 17:15hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The purpose of this inspection was to monitor compliance with the regulations and in particular, to ensure residents living in the centre were provided with the services in accordance to the centre's statement of purpose.

The inspection was facilitated by the person in charge for the duration of the inspection. The inspector used observations and discussions with residents, in addition to a review of documentation and conversations with key staff and management, to inform judgments on the residents' quality of life.

The provider, person in charge and staff team were endeavouring to ensure that residents living in the designated centre, were provided with a quality and safe service. The provider and person in charge had put a variety of systems in place to ensure that residents and their families were consulted in the running of the centre and played an active role in the decision making within the centre. Families played an important part in the residents' lives and the person in charge and staff acknowledged and supported these.

Since the last inspection there had been improvements to the quality and care and support provided to residents. In particular, improvements relating to staffing, positive behaviour support, protection and infection prevention and control had resulted in positive outcomes for residents.

The designated centre comprised of a detached bungalow, located in a suburb in North County Dublin. The house provided residents with a spacious kitchen/dining area and a large sitting room and quiet/relaxation room. The centre included two separate bathing/toilet facilities, a staff office space and an enclosed garden area to the rear. Laundry facilities were provided in a large built shed located in the rear garden area. The inspector observed that there had been upkeep and repair to the centre since the last inspection, which ensured the effectiveness of the infection protection and control measures in place. The inspector found the residents' home to be bright, airy and homely and was in line with residents' needs and preferences.

The residents' bedrooms were observed to be individually decorated and took into account their likes, interests and preferences. They included items and possessions that were meaningful to each resident. On meeting one resident in their bedroom, the inspector observed that the resident seemed proud of the way their room was decorated. They told the inspector that they liked spending time in their room. The resident showed the inspector photographs, certificates of achievement and posters and soft furnishing that included a picture of their favourite singer. Another resident was also happy to meet with the inspector in their bedroom. Their room had an array of relaxation and sensory items and lights in the room. The resident smiled and nodded when the inspector asked if they liked their room. Overall, the inspector

found from observations, talking with staff and review of documentation, that residents had been consulted in the layout and décor of their bedrooms.

The centre was supplied with appropriate manual handling aids and devices to support residents' mobility and manual handling requirements. There was an en-suite bathroom that was supplied and fitted with various assistive aids including overhead tracking hoists.

From speaking with staff and from a review of residents' healthcare support plans, the inspector found that the person in charge and staff were proactive in referring residents to healthcare professionals and ensuring recommendations were implemented. All residents were supported to access and attend specialist services when needed.

The provider and person in charge had implemented good arrangements to support residents to make choices and decisions, and consulted with them about their care and support, and on matters related to their home. Residents communicated using various means including speech and use of pictures and easy-to-read documents. Communication passports were in place to guide staff on communicating effectively with residents to ensure that they were understood.

Residents were provided with household meetings where choice was promoted and decisions made. Resident discussed menu and activity plans. In addition, topics such as complaints and safeguarding where often discussed at the meetings and easy-to-read documents were used to aid understanding.

Three residents were attending a community day service and one resident had chosen to retire from their day service. On a daily basis, the resident who had retired, was provided the choice of on-site and community activities that were in line with their likes and preferences. The inspector met with the resident who was very welcoming. They showed the inspector the sitting room and all their personal items that they enjoyed while in the room. The inspector observed the resident complete one of their household tasks of bringing the bin out to the front of the road. The resident appeared proud of this role and smiled when the inspector praised him for his work. Later in the day, the resident headed out with their staff member in a taxi to a local café. The inspector was informed that this was an activity the resident regularly enjoyed.

Residents were supported by a team of social care workers who were managed by the person in charge. On speaking with staff, the inspector found that they were familiar with the residents' different personalities and were mindful of each resident's uniqueness and different abilities. To support residents changing needs, the provider had ensured that additional staff hours provided at the weekend to ensure the safety and wellbeing of all residents.

The inspector observed kind and caring engagements between staff and residents and it was clear that management and staff understood what residents were communicating to them.

In summary, the inspector found that the person in charge and staff were striving to ensure that each resident’s well-being and welfare was maintained to a good standard. There was a strong and visible person-centred culture within the designated centre. Residents were in receipt of good quality care and support and their choices and preferences were respected. Some improvements were needed to the areas of staffing, protection and risk and these are discussed in detail further in the report.

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

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.

Overall, the inspector found that the care and support provided to residents was person-centred, and that residents' needs and wishes were taken into account. There had been improvements since the last inspection which had resulted in positive outcome for residents. However, some further improvements were needed to staffing arrangements in the centre.

The centre had a clearly defined management structure in place which was led by a capable person in charge. The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs and the supports required to meet those needs.

The registered provider had completed an annual review regarding the quality of safe care and support provided to residents during 2025. Six-monthly unannounced visits had also taken place in the centre and a suite of audits, including monthly data reports, had been carried by the person in charge.

There were clear lines of accountability at individual, team and organisational level so that all staff working in the centre were aware of their responsibilities and who they were accountable to. There were 1.5 staff vacancies in the centre at the time of the inspection and while the person in charge was endeavouring to provide continuity of care when filling the gaps on the roster, this was proving difficult where there was short-notice leave.

The inspector spoke with staff members throughout the course of the inspection. The staff members were knowledgeable on the support needs of residents. On

observing management and staff engage with residents, the inspector saw that interactions were positive, kind and caring.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. The person in charge regularly reviewed staff training needs and on the day, all staff training was found to be up-to-date.

There was appropriate information governance arrangements in place to ensure that the designated centre complied with all notification requirements.

The provider had suitable arrangements in place for the management of complaints and an accessible complaints procedure was available for residents in a prominent place in the centre.

Regulation 15: Staffing

There had been improvements to staffing levels since the last inspection in June 2024. The person in charge had carried out a roster review and additional staffing hours had been allocated to the weekend roster. The provider had ensured that hours were put in place to support residents' current and changing assessed support needs at meal times, during personal care and with their mobility needs.

In addition, near the end of 2025, due to increased risks relating to a resident's changing needs, the provider had approved addition staffing hours until the end of January 2026. On review of the resident's updated speech, language and talk (SLT) recommendations, dated January 2026, the inspector saw that additional risks had been identified due to the resident's changing needs. One-to- one supervision during mealtimes had been recommended following the SLT assessment. The person in charge brought this risk to senior management and requested for the additional hours to remain in place. However, as of the day of the inspection, they had not received a response. On speaking with the senior service manager at the end of the inspection, the inspector was informed that an extension of the additional hours had been approved by the provider.

There were 1.5 whole time equivalent social-care worker vacancies in the designated centre. The person in charge was endeavouring to provide continuity of care when filling the gaps on the roster. Members of the core staff worked additional hours to cover a number of the gaps. In addition, staff from the organisation's relief panel as well as agency staff covered the gaps.

For the most part, staff vacancies, as well as other long-term or planned leave requirements were being covered by staff that were familiar to residents. However, where there was a short-notice weekly leave requirement in the centre, this was proving difficult to ensure continuity of care. For example, on review of the roster between December 2025 and January 2026, four different agency staff and four different relief staff had been employed for one shift each to cover the short-notice

leave. This arrangement was impacting on providing continuity of care to residents and potentially impacted on promoting and maintaining relationships between residents and their staff.

There was an actual and planned roster in place and for the most part, it was maintained appropriately. However, on review of December 2025 and January 2026 the inspector saw that improvements were needed to the staff names on the roster. This was to ensure that all staff names were included in full and clearly demonstrated who was working each day. For example, the inspector saw that during the sample period not all relief or agency names were written in full.

The inspector spoke with the person in charge and three staff members throughout the day. The inspector found they to demonstrated good understanding of the residents' needs and of their individual likes and preferences.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff members were provided with a range of training as part of their professional development and to support them in the delivery of appropriate safe care and support to residents.

Staff training records showed that staff had completed training in relevant areas, such as safeguarding and protection of vulnerable adults, fire safety, managing behaviours that challenge, safe medicine practices, epilepsy, food hygiene, feeding, eating and drinking (FED), infection prevention and control, open disclosure, dignity at the workplace and first aid.

The person in charge, in line with a resident's recent diagnosis of dementia, had identified the need to provide staff training in this area. They advised the inspector that they planned to follow up with the dementia team Nurse in March regarding the training.

Supervision and performance appraisal meetings were provided for staff to support them perform their duties to the best of their ability. The person in charge showed the inspector a sample of minutes of staff supervision meeting completed during 2025. The inspector saw that staff members had been provided four meetings throughout the year, which was in line with the provider's policy.

Judgment: Compliant

Regulation 21: Records

On the day of the inspection, records required and requested were made available to the inspector. Overall, the records were appropriately maintained. The sample of records reviewed on inspection, overall, reflected practices in place.

On the afternoon of the inspection, the senior service manager organised for a sample of six staff records to be brought to the designated centre. On review of a sample of staff files (records), the inspector found that they contained all the required information as per Schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place were found to operate to a good standard in this centre. There was a clearly defined management structure that identified the lines of authority and accountability and staff had specific roles and responsibilities in relation to the day-to-day running of the centre.

The governance and management systems in place were ensuring that service delivery was safe and effective through the on-going audit and monitoring of its performance.

In December 2025, the registered provider had carried out an annual review of the quality and safety of care and support provided in the centre during 2025. The review demonstrated that residents, family members and staff had all been consulted and provided feedback regarding the service. In addition, the provider had completed unannounced six-monthly visits to the centre in April and October 2025. These visits were completed to review quality and safety of care and support provided to residents in the centre and to implement improvements where required.

The person in charge completed monthly data reports which were used at management meetings between the person in charge and service manager to review issues arising and actions required. The inspector reviewed the monthly data report for December 2025 and saw that it provided comprehensive oversight of all areas of service provision. For example, some of the areas reviewed by the report included safeguarding referrals, trust in care investigations, incident report forms, complaints and complements, staff requirements, staff training, monitoring of residents' goal progress, quality and safety checks, money audits, fire drills and environmental risks, but to mention a few.

The inspector observed other audits that were also completed by the person in charge on a regular and consistent basis. For example, residents' assessment of need audit, infection prevention and control monthly checklist, quarterly fire safety reviews, clients' money audit and medication management audit. These audits supported the person in charge in ensuring the effective governance, operational management and administration of the designated centre.

Judgment: Compliant

Regulation 31: Notification of incidents

There were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The inspector found that incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence.

It was evident that the centre strived for excellence through shared learning and reflective practices. Where there had been incidents of concern, the incident and learning from the incident, had been discussed with staff.

Where improvements were needed regarding submitting notifications to other services, these have been addressed under Regulation 8.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in place in the centre that was in an accessible and appropriate format which included access to a complaint's officer when making a complaint or raising a concern. The inspector observed an easy-read poster displayed on the centre's front hall notice board regarding the complaints procedure and details of the complaint officers.

On review of residents' weekly household meetings, the inspector saw that it included the complaints procedure on their agenda which allowed residents an opportunity to raise a concern or issue if they so wished.

There had been a complaint logged in December 2025 relating to a local parking issue. On review of the complaint log and details within it, the inspector saw that the person in charge and provider had promptly followed up and resolved the issue. The complaint form and associated emails demonstrated that an acceptable resolution had been put in place and that, overall, the complainant was satisfied with the outcome.

Judgment: Compliant

Quality and safety

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

Each resident's well-being and welfare was maintained by a good standard of evidence-based care and support. It was evident that the person in charge and staff were aware of residents’ needs and knowledgeable in the person-centred care practices required to meet those needs. Residents were supported and encouraged to have meaningful participation in their community. Overall, care and support provided to residents was of good quality however, some improvements were needed to the areas related to risk management and protection.

The physical environment of designated centre was clean and tidy and in good decorative and structural repair throughout. The design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable and homely environment. There had been improvements to the upkeep and repair of the centre since the last inspection which had brought improvement to the effectiveness of the infection prevention and control measures in place.

The provider and person in charge were endeavouring to ensure that every effort was made to allow residents communicate in a way that was in line with their needs and preferences. On observing staff engagement with residents, the inspector saw that staff understood what residents were expressing.

Individual and location risk assessments were in place to ensure that safe care and support was provided to residents. Residents were supported to partake in activities they liked in an enjoyable but safe way. Some improvements were needed to ensure that where there were changes to risk, that they were reviewed and updated in a timely manner and in line with the provider’s own policy.

The health and wellbeing of each resident was promoted and supported in a variety of ways including through diet, nutrition, recreation, exercise and physical activities. Residents received appropriate person-centred care and had appropriate access to a medical practitioner of their choice to support their health and wellbeing.

The provider and person in charge promoted a positive approach in responding to behaviours that challenge. There were systems in place to ensure that where behaviour support practices were being used, they were clearly documented and reviewed by the appropriate professionals on a regular basis.

There were restrictive practices in use in the centre. Where applied, the restrictive practices were documented and subject to review by the organisation's positive approvals management group. The person in charge and staff team were actively seeking to find and trial ways to reduce the restrictions, and in a safe way.

The person in charge and staff were endeavouring to facilitate a supportive environment which enabled residents to feel safe and protected from all forms of abuse. There was an atmosphere of friendliness, and the residents' modesty and

privacy was observed to be respected. For the most part, where incidents had occurred, they had been followed up appropriately at local level however, improvements were needed to ensure that all safeguarding incidents were submitted the national safeguarding office in line with policy and procedure.

Regulation 10: Communication

Communication access and support arrangements were facilitated for residents in accordance with their assessed needs and wishes. Residents living in this centre required support with their communication needs.

The person in charge was striving to ensure that residents were provided information in a way that they understood. The inspector observed examples of easy-to-read format in residents' personal plan and an array of easy-to-read, picture format and photographic forms of information displayed on the residents' front all notice board.

Residents' assessment of need included a communication assessment and from this a communication support plan was developed. The support care plan included the method of communication the resident used to express themselves. The information in the support plan provided guidance for staff on how to best communicate with each resident in line with their needs, wishes and preference.

In addition, the inspector observed a sample of two residents' communication passports. These documents included photographs of the residents as well as information that best described their communication profile and preferences. The communication passport was person centred in nature and reflected each resident's likes and preferences. For example, the documents included a section on how each resident liked to communicate and how they wanted staff to communicate with them. All staff had signed that they had read and understood how to use the communication passport.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed the centre's risk management policy and found that the provider had ensured that the policy met the requirements as set out in the regulations.

There was a risk register specific to the centre which was reviewed on a quarterly basis or more frequently if required. However, on the day of the inspection, the

inspector found that the risk register had not been reviewed since quarter three of 2025.

There was an array of individual and location risk assessments in place to ensure that safe care and support was provided to residents. However, where there had been changes to the level of risk, as well as measures, not all associated risk assessments had been updated to reflect this.

The inspector reviewed the centre and individual risk assessment that related to feeding, eating and drinking. Both assessments were rated a high red due to the level and impact of the potential risk of choking. The centre risk assessment dated April 2025 and a resident's risk assessment dated January 2025, required updating so that they included the current measures in place and reflected a more accurate risk rate.

For example, at the end of October 2025 the provider had increased staffing hours at weekends to ensure there was sufficient staff in place to supervise residents during mealtimes. This was in line with residents' speech and language (SLT) feeding, eating and drinking guidelines and recommendations. There was evidence to demonstrate that this measure (increased staffing hours) had reduced the level and impact of risk related to choking. This information was pertinent when reviewing staff rosters and assessing the number of staff required to meet the residents' needs.

On the day of the inspection, the person in charge reviewed and updated the resident's risk assessment and included all measures in place, including the additional staff hours, which in turn decreased the risk and resulted in a lower risk rating.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The Inspector found that since the last inspection, there had been improvements to the effectiveness of the infection prevention and control measures in place. This was primarily due to the upkeep and repair of the centre since the last inspection. Areas of the premises had been painted and a number of door-frames had been provided additional covering to reduce the risk of chipping and damage from wheelchairs.

On walking around the centre, the inspector observed the house to be clean and that cleaning records demonstrated a high level of adherence to cleaning schedules.

There was an up-to-date comprehensive policy relating to infection, prevention and control in the designated centre and it was made available to all staff.

In addition there were an array of guidance documents to support staff know how to complete clearing tasks as well as what products to use. This included information on colour coded equipment when cleaning.

Staff had completed specific training in relation to the prevention and control of infection.

The provider and person in charge had ensured that local monthly infection prevention and control audit were being complete as part of the monthly data report, which included an infection prevention and control checklist.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, the registered provider had ensured that there was effective fire safety management systems in the centre that ensured the safety of residents in the event of a fire.

Staff had completed fire safety training and were knowledgeable in how to support residents evacuate the premises, in the event of a fire.

Staff completed daily, monthly and quarterly fire checks. The emergency lights, fire alarms, blankets and extinguishers were serviced by an external company within the required time frame.

The person in charge had prepared fire evacuation plans and resident personal evacuation plans. These were in place for staff to follow in the event of an evacuation. The plans provided clear guidance to staff to ensure a timely evacuation in the case of fire.

All residents were evacuated through the front of the house however, there was an evacuation route from the back of the house. The person in charge advised the inspector that the fire officer had reviewed the path and grass way from the back of the house to the front and found that it was accessible for all residents in the event of fire.

Daytime and night time fire drills, to test the effectiveness of the fire evacuation plans, had been carried out in June and August 2025. On review of the drill records, the inspector saw that no issues were identified and residents were evacuated in a timely manner.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medicines used in the designated centre were found to be used for their therapeutic benefits and to support and improve each resident's health and well-being.

The provider and the person in charge had ensured that appropriate systems were in place for the ordering, receipt, prescribing, storing, disposal and administration of medicines and that there were satisfactory safe medical systems in place that included robust oversight systems.

Staff were competent in the administration of medicines and were in receipt of training and ongoing education in relation to medicine management. A member of the staff team showed the inspector the medication cupboard and the systems, protocols and processes in place for the safe management of medicine. The staff was knowledgeable on medicine management procedures and on the reasons medicines were prescribed. The medication administration records also indicated that medications were administered as prescribed.

There were appropriate oversight systems in place to ensure safe medication practices and to ensure their effectiveness. All medicine errors and incidents were recorded, reported and analysed and learning was fed back to the staff team to improve each resident's safety and to mitigate against the risk of recurrence. Medicines management was audited regularly in order to provide appropriate oversight over medicine management.

Judgment: Compliant

Regulation 6: Health care

The inspector found that appropriate healthcare was made available to all residents having regard to their personal plan. Plans were regularly reviewed in line with the residents' assessed needs and required supports.

There were an array of healthcare support plans in place to support staff in their practice when supporting each resident with their health. For example there were support plans relating to residents' general health, allergies, respiration difficulties, blood pressure, acid reflux, feeding eating and drinking, mobility, personal care and hair and nail care, but to mention a few.

In addition, residents' health and wellbeing was promoted and supported in a variety of ways including through diet, nutrition, recreation, exercise and physical activities. On review of residents' menu plans and food in the cupboards and fridges, the inspector found that the choice of food, beverage and snacks offered to residents was varied, nutritious and in line with each resident's likes and tastes.

Residents' healthcare plans demonstrated that each resident had access to allied health professionals including access to their general practitioner (GP)

The designated centre provided a range of specialised supports to residents. Access to these supports was through an assessment and referral process utilising a multidisciplinary clinical support team (MDT). On review of residents' support plans the inspector saw that regular clinical support was provided in the centre and access to specialist clinicians and consultants as was provided as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector found that there had been improvements to the positive behaviour supports provided to residents in the centre. On a review of a sample of two positive behaviour support plans, the inspector found that plans were up-to-date and included satisfactory guidance to enable staff support residents manage their behaviours. All plans were developed, written and had oversight by, an appropriate allied health professional or clinician. These improvements meant that the provider could be assured that evidence-based specialist and therapeutic interventions were effectively implemented in line with national and centre policies.

In line with the organisation's policy, the provider had a very clear restrictive practice assessment process in place. All restrictive practices were risk assessed. Where applied, the restrictive practices were clearly documented and were subject to approval and review by the organisation's positive approach monitoring group.

On speaking with the person in charge, the inspector was informed that they were always looking for ways to reduce restrictions in place. For example, the person in charge and staff team had trialled the removal of locks on external bins. While this was not a success at the time, it demonstrated the culture in place for reviewing and attempting to reduce restrictions.

Judgment: Compliant

Regulation 8: Protection

There had been improvements since the last inspection of the centre that saw a reduction in safeguarding incidents occur in the centre. There were adequate supports and resources in place to ensure residents felt safe in their home which overall resulted in a positive lived experience for residents in their home.

Effective positive behaviour support plans as well as additional staffing hours saw a reduction in the risk of incidents occurring. On the day of the inspection, the

inspector was advised that compatibilities issues in the house had subsided. This was also partly due to a resident's change in support needs.

Residents, who required such support, were provided with personal intimate care support plans. The support plans were in line with each resident's personal plan and in a manner that respected each resident's dignity and bodily integrity.

All staff had been provided with training in safeguarding and protection of vulnerable adults. On review of a sample of Schedule 2 staff files the inspector saw that all staff had up-to-date Garda vetting completed.

On review of safeguarding plans and records the inspector found that where safeguarding incidents had occurred in the centre, the person in charge had followed up appropriately. The had ensured that safeguarding incidents were reviewed, screened, and reported to the appropriate designated officer.

However, on the day of the inspection, there were no records to demonstrate that two preliminary screening forms had been submitted to the national safeguarding team in line with safeguarding policy and procedures. While the actions on the interim plan had been completed, there had been no oversight or response to the interim plan by the national safeguarding team.

As such, systems in place to that ensured safeguarding incidents were follow up in line with national policy and procedures, were not always effective.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Fox's Lane Residential OSV-0002366

Inspection ID: MON-0045429

Date of inspection: 29/01/2026

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: · DASMT reflective of additional staffing requirement to support high levels of supervision for resident re; FEDS support, submitted and approval for staffing supports in place pending outcome of same. · Ongoing Organizational and Designated Centre specific recruitment campaigns running with scheduled interviews on the 26/2/2026 · Relief and agency records sheets now reflect – staffs full name and Employee number. 30/1/2026 · Relief staff have been assigned against 1 WTE vacancy in the interim- · Continued Use of regular relief and or agency to address short- term vacancies and minimize the use of unfamiliar staff · Staff sick leave is managed in line with the Sick Leave and Attendance Management Policy / Procedures	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: · Risk register updated reflective of Q4 submission requirement – 18/2/2026 · Review of all risk ratings associated with Generic- Risk assessments and Service user specific Risk assessments to reflect the reduced rating consistent with impact of additional control measures 18/2/2026	

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
- Notifications resubmitted to the Designated Officer for follow up with national safeguarding team -------- 30/1/2026

- Safeguarding Audit scheduled for the 9/3/2026

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/04/2026
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.	Substantially Compliant	Yellow	30/04/2026
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	30/01/2026

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	18/02/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/01/2026