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:	Ballymun Road
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	05 May 2026
Centre ID:	OSV-0002379
Fieldwork ID:	MON-0050213

About the designated centre

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

Ballymun Road is a designated centre operated by Saint Michael's House located in North County Dublin. It provides a community residential service to six adults with intellectual and physical disabilities. Each person has their own bedroom. There is a communal kitchen /dining room and a separate shared sitting room area. There is a large enclosed back garden with patio and garden furniture. The centre is staffed by the person in charge and social care workers. Ballymun Road aims to provide a homely environment where individuals are supported to live as independently as possible and make choices about their lives.

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 5 May 2026	11:00hrs to 19:30hrs	Karen McLaughlin	Lead

What residents told us and what inspectors observed

This unannounced safeguarding thematic inspection was carried out to assess the provider's regulatory compliance with the relevant safeguarding regulations and adherence to the National Standards for Adult Safeguarding. Safeguarding extends beyond the prevention of abuse, exploitation, and neglect. It involves a proactive approach, recognising safeguarding concerns, and implementing measures to protect individuals from harm. It is also about promoting the human rights of residents and empowering them to exercise control over their own lives.

Previous inspections of the centre had found ongoing and longstanding incompatibility issues between residents that were adversely impacting their safety and wellbeing. Following the last inspection of the centre in May 2025, the provider attended a warning meeting with the Office of the Chief Inspector of Social Services (Chief Inspector) due to the poor findings in relation to the safeguarding of residents from peer-to-peer abuse. The provider submitted a compliance plan with actions to mitigate these issues and a non-standard restrictive condition had been added to the registration of this designated centre in May 2025 as part of it's registration renewal. The condition had required the provider to come into compliance with the regulations by implementing their transition plan dated 20/05/2025 to the satisfaction of the Chief Inspector no later than 31/03/2026.

In advance of this inspection, the provider had submitted an application to vary the time line attached to the centre's non-standard restrictive condition to the Chief Inspector. An updated plan outlining how the provider intended to successfully complete the transition within the revised timeframe was also submitted.

The purpose of this inspection was to assess the effectiveness of the actions being taken by the provider to address the ongoing incompatibility concerns and to review the progress made by the provider regarding the transition of a resident to alternative accommodation. This inspection also considered the effectiveness of the measures implemented to mitigate the ongoing safeguarding concerns.

The inspector used observations, in addition to a review of documentation, and conversations with staff and residents to form judgements on the residents' quality of life. The inspection was conducted over a single day and was facilitated by staff on duty as the person in charge was on leave.

The centre comprised of a large two-storey house located in North Dublin. The centre is located close to many services and amenities, which were within walking distance and had good access to public transport links. There were five residents living in the centre with one vacancy. The provider did not plan to fill this vacancy until the current incompatibility issues were resolved.

Many aspects of the service provided to residents were to a high standard, and while the provider and person in charge had made extensive efforts to ensure that residents were safe from potential abuse in the centre, their efforts were not effective. The incompatibility of residents and associated safeguarding concerns had not been resolved.

The inspector acknowledged the provider's efforts to address the incompatibility issues through the identification of a new home for one resident and the development of a transition plan. In the interim, the inspector was satisfied that the provider had taken reasonable steps to maximise the current living arrangements and support the safety and well being of all residents.

During the inspection, the inspector spoke with three staff members on duty, and found that all were highly knowledgeable about the residents' support needs and their responsibilities in providing care. They all spoke about the residents warmly and respectfully, and demonstrated a rich understanding of the residents' assessed needs and personalities and demonstrated a commitment to ensuring residents needs were met to a high standard at all times. They also took time to discuss residents' changing needs and the support plans that had been implemented as a result.

The residents had varied health and social support needs and levels of independence. The inspector observed staff to be very familiar with the residents communication style and preferences. Residents were familiar with the staff and felt comfortable interacting and receiving care. It was clear that staff had developed and maintained therapeutic relationships with residents.

The inspector met with all five residents. On arrival, four residents were attending day service, another resident was being assisted with their morning routine by staff, with plans to go to the gym. One resident returned early afternoon for reflexology at home and another returned shortly after and had coffee with the inspector.

Three staff were on duty the day of the inspection and they were actively present in the communal areas of the house.

Two residents had just returned from a holiday and enjoyed it so much they were booking to go again. One resident told the inspector they had a cabin with an outdoor hot tub.

Three residents happily showed the inspector their respective bedrooms, which featured artwork on the walls and photographs of family and friends. Two residents accompanied the inspector on a walk about of the beautifully landscaped garden space. The inspector observed dinner with three residents and watched TV with another resident.

One resident told the inspector about how their quality of life was being impinged on. They told the inspector that they didn't get along with another resident and wanted them to move out. They said that they stayed in their bedroom and did not access the communal areas such as the kitchen and sitting room without staff.

While, the inspector did not observe any safeguarding incidents during the inspection, they did observe residents retreat from the communal areas when the other resident was present. Residents spent most of the evening after dinner in their bedrooms. Furthermore, the inspector observed that one resident made sure staff were present before she entered the shared areas of the house.

A providers safeguarding audit dated 04/12/2025 detailed unresolved complaints from the residents regarding incompatibility. The audit documented that 'residents wish to live in a house where they feel safe from intimidating behaviour and their daily routines are not being controlled/dictated to'. It further stated that 'one resident has said they are scared of another resident and they make them sad', the assessment said that this resident's entire evening revolves around the other resident. They will not access the kitchen or sitting room unless staff are present and the other resident has left.

The safeguarding audit, last reviewed 08/04/2026, indicated a reduction in the safeguarding incidents relating to resident incompatibility. However, residents no longer wished to live with each other and, due to the nature and frequency of incidents, the implementation of a rights-based approach to care continued to present challenges within the centre. Further improvements were therefore required.

The next two sections of the report presents 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, with a particular focus on safeguarding.

Capacity and capability

The registered provider had implemented management systems to monitor the quality and safety of the service provided to residents including annual reviews and six-monthly reports, plus a suite of audits. However, they had not ensured that the service provided in the centre was safe and appropriate to meet the residents' needs.

While the provider had made extensive efforts to address these matters including plans to transition one resident, the efforts so far have not been fully effective and the provider had not met the timeline they set out to transition the resident.

Some improvements had been made since the previous inspection in relation to some resources, such as the staffing arrangements, and the provider had applied to extend the time frame of the non standard condition applied to the centres registration.

While the provider had responded to safety concerns by increasing staff to resident ratios, enhancing the staffing skill-mix, and introducing additional supports to residents, such as a more structured routine and activity planning, significant gaps in service delivery remained. These shortcomings presented substantial risks to the effective operation of the centre and impacted the provider's ability to maintain a safe and supportive environment, particularly in relation to Regulations 5: Individualised assessment and personal plan, Regulation 8: Protection and Regulation 9: Residents rights.

Notwithstanding the above, the inspector found that at a local level in the centre there was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The person in charge was full-time and supported in the management of the centre by a service manager. The person in charge reported to a service manager and Director, and there were effective systems for the management team to communicate and escalate any issues.

The provider ensured that there were suitably qualified, competent and experienced staff on duty to meet residents' current assessed needs. There was a planned and actual roster maintained for the designated centre. Rosters were clear and showed the full name of each staff member, their role and their shift allocation.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents.

Staff also attended regular team meetings which provided an opportunity for them to any raise concerns regarding the quality and safety of care provided to residents.

Regulation 15: Staffing

Residents were in receipt of support from a stable and consistent staff team. Staffing levels were in line with the centre's statement of purpose and the needs of the residents.

The inspector reviewed actual and planned rosters for April and May 2026. The person in charge maintained a planned and actual staff rota which was clearly documented and contained all the required information.

On the day of the inspection, the provider had ensured there was enough staff with the right skills, qualifications and experience to meet the assessed needs of the residents at all times in line with the statement of purpose and size and layout of the designated centre. The provider had provided additional staffing resources as a measure to reduce the safeguarding concerns in the centre.

Staff on duty told the inspector that the complement and skill-mix was sufficient and that the additional support measures have had a positive impact on safeguarding

residents. Live night and sleepover staff were utilised to support residents changing needs and to mitigate compatibility issues.

Furthermore, the inspector found that staff spoken with had a good understanding of residents' individual personalities and needs, and supported them in a kind and respectful manner.

Judgment: Compliant

Regulation 16: Training and staff development

Staff working in the centre had access to appropriate training as part of their continuous professional development, and to support the delivery of care to residents.

All staff, completed a suite of training as part of the systems to safeguard residents and promote their rights in the centre. The training included, safeguarding of residents from abuse, positive behaviour support, human rights, and the management of behaviours of concern.

The inspector reviewed the staff training records maintained by the person in charge and found that it was effective in regularly monitoring staff training.

In addition to the staff supervision and support arrangements, staff also attended regular team meetings which provided an opportunity for them to raise any concerns about the quality and safety of care and support provided to residents.

Judgment: Compliant

Regulation 23: Governance and management

While the management team had good oversight of the risks presenting in the centre such as the safeguarding concerns, and were endeavouring to resolve them, the registered provider had not ensured that the centre was adequately resourced to provide safe and consistent care in relation to the accommodation needs of one resident.

A non-standard restrictive condition had been added to the registration of this designated centre in May 2025 as part of it's registration renewal. The condition had required the provider to come into compliance with the regulations by implementing their Transition Plan dated 20/05/2025 to the satisfaction of the Chief Inspector no later than 31/03/2026. While the provider had made extensive efforts to address

this matter their efforts had not been fully effective and they had failed to transition a resident out of the centre to a more suitable environment.

Prior to this inspection, the provider had submitted an application to vary the time line attached to the centre's non-standard restrictive condition to the Office of the Chief Inspector. An updated plan outlining how the provider intended to successfully complete the transition within the revised timeframe was also submitted.

The Provider had identified another centre for conversion that may better meet the needs of a specific resident. Engagement with their funder was ongoing and the provider was reviewing internal resources to support the resident's transition. The provider is committed to resolving the incompatibility issues by transitioning one resident to a more appropriate home by 31 March 2027.

On the day of this inspection, the inspector noted that some progress had been made in improving the quality of the service being provided to residents. For example, the provider had provided assurances that the designated centre will remain at five-bedroom capacity until the compatibility issues were resolved. Staffing levels also remained unchanged despite the reduction in capacity from six to five residents, resulting in increased support for residents.

In addition, the development of a second sitting room will provide an extra communal space, allowing residents greater privacy from one another and a suitable area for visits with family and friends. As a result of the increased staffing levels and additional supports, there had been a reduction in safeguarding concerns.

Safeguarding concerns were well documented and due to the complex nature of the incompatibility issues, the introduction of ongoing multi-disciplinary meetings and increased staffing demonstrates a concerted effort to mitigate against safeguarding risks and improve residents quality of life.

While a number of good practices were observed at a local level within the centre, the quality of care was significantly impacted by ongoing safeguarding concerns arising from resident incompatibility. The inspector found that, although the provider had implemented measures to reduce incompatibility related issues within the house, the overall impact of incidents continued to negatively affect residents' quality of life.

Judgment: Not compliant

Quality and safety

This section of the report provides an evaluation of the quality of services delivered and the effectiveness of measures implemented to ensure the safety of residents. Regulations pertaining to safeguarding were specifically assessed as a part of this

inspection. Safeguarding involves a proactive approach, recognising safeguarding concerns, and implementing measures to protect individuals from harm.

This inspection found there were many aspects of residents' wellbeing and welfare that were being upheld by a good standard of evidence-based care and support. However, not all residents' assessed needs were being met in the centre. This was adversely affecting the quality and safety of service provided to residents and was contributing to ongoing and prolonged compatibility issues, which continued to give rise to safeguarding concerns.

While the provider was making efforts to source suitable accommodation for one resident, these unmet needs continued to present significant compatibility and safeguarding risks between residents.

The provider had good arrangements for managing safeguarding concerns including staff training and the development of safeguarding plans.

However, despite these measures, the risks to resident safety had not been fully mitigated, and residents remained at risk of harm from other residents within the centre.

Where required, positive behaviour support plans were developed for residents, and staff were required to complete relevant training to support residents to manage behaviours of concern.

Some residents also required support with communication. The inspector saw that staff members were familiar with residents' communication needs and were able to effectively support residents to engage in conversations with the inspector.

Overall, the inspector found that the quality and safety of the service provided to residents were significantly compromised due to ongoing deficits and risks relating to the meeting of residents' assessed needs, safeguarding arrangements and the protection of residents' rights.

Regulation 10: Communication

The inspector found that residents were supported by staff who understood their communication needs and could respond appropriately.

There were comprehensive communication plans in place that gave clear guidance and set out how each person communicated their needs and preferences.

Staff were well informed about each resident's individual communication needs. Throughout this inspection, the inspector observed that staff demonstrated flexibility and adaptability in their use of various communication strategies. Residents were

actively supported and encouraged to communicate with their families and friends in ways that suited their preferences.

Communication aids, including visual supports, had been implemented in line with residents' needs and were readily available in the centre. Additionally, important information, such as the schedule for the day were displayed in an easy to read format. The inspector observed a lot of the signage in the centre was in easy-to-read, such as menu planner, daily and weekly planners and local community activities and events. This supported residents to understand and engage with the information provided.

Residents had access to relevant communication media including personal mobile phones, televisions and streaming services.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured assessments of residents' needs were completed and informed the development of personal plans. There was a comprehensive assessment of need in place for each resident, which identified their healthcare, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness.

The inspector reviewed three residents' assessments and plans. The plans, including those on personal, health, and social care needs, were up to date, sufficiently detailed, and readily available to staff in order to guide their practice.

The plans also described the residents' individual personalities, interests, abilities and how they liked to spend their time. The inspector saw evidence that residents were able to take part in activities and goals of their own choosing. The assessments and plans were reviewed on a regular basis, and included input from the residents and various multidisciplinary team services.

It had been identified that centre was not fully suitable to meet the needs of all residents, particularly in relation to the required living arrangements for one resident and their incompatibility with other residents, which was contributing to ongoing safeguarding concerns. The provider remained committed to sourcing appropriate accommodation, and until then were utilising additional resources such as increased staffing and multidisciplinary team services.

These deficits are discussed further and actioned under Regulation 8:Protections and Regulation 9: Residents Rights of this report.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required support with managing behaviour had access to multidisciplinary professionals including psychiatry and psychology. Behaviour support plans were in place on residents' files. These were reviewed and updated regularly. Staff were informed of the recommendations in place to assist residents in this area.

To support the protection of residents and try reduce the risk of peer to peer safeguarding incident, residents were provided with safety plans, positive behaviour support plans and well being support plans.

The inspector reviewed two behaviour support plans in place for residents. The plans detailed proactive and reactive strategies to support residents in managing their behaviour. They were devised in consultation with the clinical team and considered other guidelines such as safety plans, safeguarding, routine management and communication. The plans were reviewed regularly as per the providers policy.

There was evidence of consent and engagement obtained from one resident who showed the inspector work they were doing about appropriate routines that do not impact on other residents.

Staff received training in managing behaviour that is challenging and participated in regular refresher courses based on best practices.

The inspector completed a review of restrictive practices in place in the centre and found that all restrictive practices were logged, regularly reviewed and risk assessed in line with the provider's policy.

Judgment: Compliant

Regulation 8: Protection

Safeguarding is a critical responsibility for providers in designated centres. The registered provider had arrangements to safeguard residents from abuse, such as staff training, appropriate staffing levels, and reporting systems. However, the risk to residents' safety had not been mitigated, and residents remained at risk of harm from other residents in the centre.

Safeguarding concerns had been reported, responded to, and managed in line with the provider's policy. Safeguarding incidents were notified to the safeguarding team and to the Chief Inspector in line with regulations.

The inspector found that when concerns arose, measures were implemented to protect residents from further abuse.

Safeguarding plans had been developed outlining interventions to help protect residents from abuse. However, staff reported that these plans had limited effectiveness and highlighted ongoing challenges in ensuring resident safety.

Additional support from the multidisciplinary team was provided, and increased staffing resources were allocated to the centre. Staff also implemented the associated behaviour support plans.

Despite these measures, the plans were not consistently effective, and residents remained at risk of exposure to abusive behaviours.

Due to safeguarding risks, some residents chose not to be left unsupervised with other residents in the communal areas of their home.

Concerns regarding resident safety were also reflected in internal audits, the annual review, management meeting minutes, assessments, safeguarding documentation and in complaints raised by residents and their families.

An alternative living arrangement had been identified for one resident; however, this was still at an early scoping stage and plans were not yet fully developed. This situation continued to impact all residents living in the centre, as unmet needs contributed to ongoing risks associated with incompatibility and safeguarding.

More recently, there had been a reduction in safeguarding incidents, with six safeguarding incidents, pertaining to incompatibility submitted to the Chief Inspector since January 2026. However, staff indicated that this reduction was largely due to the residents changing their routine and increased activities outside the centre to avoid conflict.

As the current proposed plans were dependent on external factors and funding, there remained a significant likelihood that the safeguarding incidents would continue in the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

All residents have the right to safety and to live free from harm, which is essential for delivering high-quality health and social care. Residents should be able to trust the provider, person in charge, and the staff to help them feel secure. Therefore,

effective safeguarding depends on collaboration among individuals and services to ensure that residents are treated with dignity and respect, and are empowered to make decisions about their own lives.

While there were arrangements to promote the rights of residents in the centre, residents' rights were being impacted by the ongoing incompatibility issues. Some residents had expressed a wish not to live with each other, and this had not been achieved yet to ensure that their needs were being met. Some residents do not feel safe at home and one resident told the inspector 'its hard, things are still the same'.

The inspector found evidence that the person in charge and staff team were ensuring that residents knew how to make a complaint and could freely make complaints in an accessible manner. Complaints reviewed by the inspector demonstrated a consistent theme relating to residents' rights regarding their privacy and living space and ultimately the right to peace in their own home. Complaints from residents regarding safeguarding, albeit managed appropriately and in line with the provider's complaints policy and procedures, remained unresolved on the day of inspection.

Due to the nature and frequency of incidents within the designated centre, the overall environment was not conducive to enable all residents to exercise choice and control over their daily lives. As a result, most of the residents chose to avoid the communal living space, leading to restrictions in how freely they moved around their own home. On reviewing one residents file, the resident had expressed a personal goal was to have access to a big sitting room, 'where I can invite my friends, over any time I like.' The same resident had expressed this wish to the inspector during the last inspection. This goal was being worked towards at the time of the inspection.

Notwithstanding the above the inspector saw that residents were treated with dignity and respect by staff members on the day of the inspection, and saw that interactions were respectful. The inspector observed residents expressing their choices to staff regarding what they wanted to do and when they needed support.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ballymun Road OSV-0002379

Inspection ID: MON-0050213

Date of inspection: 05/05/2026

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:

• 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. The Provider will furnish the regulator with the project plan, and the PIC/Service manager will provide monthly updates as previously agreed, the 1st of every month on the schedule of works until the centre comes into compliance.
• The Registered Provider will continue to raise on-going compatibility issues within the centre with the HSE.
• The PIC and Service Manager will review safeguarding and all risk assessments relating to compatibility within the centre and assess the existing and additional control measures in meeting the needs of all residents.
• The current resident vacancy in 83 Ballymun Road will remain unfilled until the compatibility is resolved.
• As outlined in previous updates to the regulator, enhanced staffing levels will remain in place until the compatibility is resolved. This has provided great additional support for the residents and has resulted in a reduction of safeguarding incidents.
• The use of a second sitting room is now in place for the residents. This will provide for a second communal space allowing residents to have space from other residents and have a space for visiting family and friends.
• Annual Report for 2025, noted that the residents feel the staff team support them to feel safe and protected in their home.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Registered Provider will continue to raise on-gong compatibility issues within the centre with the HSE.
• The PIC and Service Manager will review the safeguarding and all risk assessments relating to the compatibility within the centre and assess the existing and additional control measures in meeting the needs of all the residents.
• SMH Safeguarding Audit was completed by the safeguarding team 22.05.2026 from the audit, it was noted that there has been a reduction in the PSF1s involving one resident in the last six months and that safeguarding support plans are being adhered to.
• All staff have completed safeguarding training.
• Safeguarding and managing compatibility is discussed at every monthly team meeting.
• Updated PBS plans in place that support staff to manage behaviours that challenge that may be impactful on others.
• MDT and safeguarding clinical reviews scheduled for all residents for 30.06.2026 to discuss current individual needs and support required.
• Support Plans reviewed quarterly or when required for all residents
• Assessment of Need (AON) reviewed for the other residents
• The PIC and PPIM of the centre will continue to submit notifications and PSFs as required
• The current resident vacancy in 83 Ballymun Road will remain unfilled until the compatibility is resolved
• As outlined in previous updates to the regulator, enhanced staffing levels will remain in place until the compatibility is resolved. This has provided great additional support for the residents and has resulted in a reduction of safeguarding incidents.
• The use of a second sitting room is now in place for the residents. This will provide for a second communal space allowing residents to have space from other residents and have a space for visiting family and friends.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The service manager will visit the residents within the centre by 30.06.2026 to provide an update on open complaints and advise residents of proposed plans as outlined above. accessible information on rights, complaints, and advocacy services is in place for the residents. There is an active complaint log in place.
• The reinstated use of a second sitting room is now in place for the residents. This will provide for a second communal space allowing residents to have space from other residents and have a space for visiting family and friends.
• As outlined in previous updates to the regulator, enhanced staffing levels will remain in place until the compatibility is resolved. This has provided great additional support for the residents and has resulted in a reduction of safeguarding incidents.
• Increased staffing allows for individual activity programmes based on residents' interests, abilities, and preferences.
• Monthly residents' meetings are held and actions arising document. Ensure feedback is acted upon and communicated.

- All staff have received Rights Training
- PIC will provide a progress update to the National advocacy service.

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)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2026
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.	Not Compliant	Orange	31/12/2026