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:	49 Rathbeale Road
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	01 December 2025
Centre ID:	OSV-0002393
Fieldwork ID:	MON-0047831

About the designated centre

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

This is a designated centre operated by St Michael's House and is located in North County Dublin. It provides a community residential service for up to five adults with a disability on a 24 hour seven days a week. The designated centre is a detached dormer bungalow which consisted of two sitting rooms, a kitchen, five bedrooms, staff sleepover room, spare room, two shared bathrooms and a utility room. The person in charge in the centre is responsible for this centre only. They are supported by a staff team of social care workers 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
Monday 1 December 2025	10:15hrs to 17:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This unannounced risk-based inspection took place over the course of one day and was to monitor the designated centre's level of compliance with the Regulations and to review the improvements the provider had made since the last inspection where a high level of non-compliances were previously found.

The findings from this inspection demonstrated the provider had made significant improvements and had addressed many of the deficits found on the previous inspection to good effect.

For the most part, the inspection was facilitated by the person in charge. A social care worker, who supports the person in charge with some of the administrations tasks, was also available on the day. Observations and interactions with residents, in addition to a review of documentation and conversations with key staff, were used to form judgments on residents' quality of life.

The inspector found that the staff team were endeavouring to ensure that residents living in the designed centre were supported to enjoy a good quality life and that their well-being and welfare was maintained by a good standard of evidence-based care and support. The staff team promoted an inclusive environment where each of the resident's needs, wishes and preferences were taken into account.

Residents were facilitated to exercise choice across a range of therapeutic and social activities and to have their choices and decisions respected. The person in charge was ensuring that residents were provided meaningful activities in the community to ensure positive outcomes for residents in terms of the their wellbeing and development.

The inspector spoke with four residents on the day. In the morning, the inspector met with two of the residents who were at home. One resident was provided a day service from their home and the other resident had chosen to take the day off from their day service to meet up with friends in the city centre.

One of the residents showed the inspector their bedroom. They told the inspector that their room had been recently painted and new flooring had been installed. They said they were happy with the improvements and advised that they had been consulted in the colour of their room. The resident told the inspector that they liked living in their house and were happy with who they shared their home with.

The inspector observed the other resident having a cup of tea and chat with staff for most of the morning. There were plans in place for the resident to head out in the afternoon with their staff member to meet up with a group of friends.

The inspector met with three other residents in the afternoon when they returned from their community day service. The inspector observed the residents sitting

together in the kitchen enjoying their evening meal together. After their meal, the inspector observed four of the residents sitting together listing to music on headphones, using their electronic devices and watching television. The residents appeared content in the company of each other and there was a relaxed and friendly atmosphere in the room.

One resident said they were happy to show the inspector their room. They told the inspector that their room had been painted and that they had chosen the colour of paint for the walls. They said that they liked their room and the way it was laid out. However, they did note that they would like to have their pictures put back up on the wall. The person in charge advised that they would contact the maintenance team for the pictures to be put back up on the walls.

While in the room, the inspector observed a rubber door stopper on the floor. The person in charge promptly went to remove it, however, the resident picked it up and said that they needed it. The inspector was informed that the resident liked their room laid out a certain way which included a chair behind the bedroom door. However, this impinged on the fire safety electronic device keeping the door held open. The inspector was informed that staff had encouraged the resident on numerous occasions to move the chair however, these attempts had been unsuccessful.

On speaking with staff members, the inspector found that they were aware and knowledgeable of the needs of residents and supports required to meet those needs. Staff acknowledged and relayed the positive changes in the centre since the last inspection and in particular, regarding the new management arrangements in place. They also told the inspector about improvements to the premises and the positive outcomes it resulted in for residents. Staff also informed the inspector that one resident's on-site day service had been improved with addition staff resources and a new activity timetable. They also informed the inspector that all the residents living in the centre enjoyed each others company and overall, were supported to enjoy a good quality of life.

The person in charge accompanied the inspector during an observational walk-around of the centre. There had been a lot of improvements to the upkeep and repair of the centre. The inspector observed new flooring throughout the premises and newly painted walls in the hallway and in residents' bedrooms.

The centre comprised of a detached dormer bungalow with a garden to the front and back of the house. Inside the premises there was a large open plan kitchen with a dining area. Residents were provided with two sitting rooms, one sitting room was part of the open plan kitchen, the other sitting room was a smaller room where residents could spend time on their own if they wished.

Residents were provided with their own bedrooms which were laid out in line with each of their wishes and preferences. All bedrooms were observed to be clean and tidy and provided a suitable space for residents to relax and sleep in. In one resident's bedroom the inspector observed a lot of their personal possessions lying around the room. There was a lot of storage cupboards and shelves in the room

however, considering the amount of possession and clothes that was contained within the room, a review of storage arrangements was needed.

Overall, the house presented as comfortable and homely environment. While a some areas in the kitchen and utility room were observed to require upkeep and repair the provider had plans to complete further works in the house in 2026 which included a new kitchen fit-out.

Residents were encouraged and supported around active decision making and social inclusion. Residents were provided with weekly house meetings where the agenda included topics such as menu planning and weekly activities. Residents were also supported to learn about the complaints procedure, how to keep safe and other current topics that were important to them, as part of the meetings.

The inspector observed that the residents seemed relaxed and happy in the company of staff and that staff were respectful towards the residents through positive, mindful and caring interactions. On observing residents interacting and engaging with staff using different styles of communication, it was obvious that staff interpreted what was being communicated. However, on review of residents' personal plans, the inspector found that some improvements were needed to their communication support plans.

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 relationships and in particular, made strong efforts to facilitate and enable residents to keep regular contact with their families.

In summary, the inspector found that each resident's wellbeing and welfare was maintained to a good standard and that there was a strong and visible person-centred culture within the designated centre. The inspector found that improvements in the centre since the last inspection had resulted in numerous positive outcomes for the residents living in the centre. This inspection found there were some further improvements required in the areas of staff training, resident personal plans and aspects of the premises.

These are discussed further in the next two sections of the report which 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.

The previous inspection of the centre in March 2025 found a significant decline in compliance which was impacting negatively on the quality of safety and care provided to residents. The provider was required to attend an escalation meeting with the Office of the Chief Inspector of Social Services and provide assurances of bringing the centre back into compliance. The purpose of this inspection was to monitor the provider's compliance with the regulations and to follow up on quality improvements that the provider had committed to implementing.

The findings on this inspection demonstrated the provider's actions to bring the centre back into compliance had been overall very effective and significant improvements were found in the areas of fire safety precautions, risk management, premises upgrades, governance and management and staffing resources.

These improvements were having a positive impact and outcome for residents living in the centre thereby demonstrating the provider's capacity to put effective action plans in place and the capability to complete those actions in order to bring about compliance with the regulations and ensure an improved quality of service provision for residents.

The centre had a clearly defined management structure in place which was led by a capable person in charge. Since the last inspection, a new person in charge had been appointed and had commenced their role in June 2025. The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs and their regulatory responsibilities.

For the most part, governance systems the provider had put in place, ensured service delivery was safe and effective. Governance oversight systems such as ongoing auditing and monitoring of the service provision were in place and the provider had complied with their regulatory responsibility and had completed an annual review of the quality and safety of care during 2024 and two six-monthly unannounced provider-led audits of the centre had also been completed, with the most recent review completed in November 2025. However, some improvements were needed to ensure that adequate systems were in place to support the person in charge with their own audits and quality reviews of the centre.

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 was a staff roster in place and it was maintained appropriately. There had been improvements to staffing arrangements due to a decrease in staff vacancies. However, a review of resources, in terms of administration hours, was required to ensure that adequate time was in place for local management and staff to carry out administrative duties as well as attend training courses.

There was a training schedule in place for all staff working in the centre and this was regularly reviewed by the person in charge. However, improvements were

needed so that all staff training was up-to-date.

Incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. There were appropriate information governance arrangements in place to ensure that the designated centre complied with all notification requirements.

Regulation 14: Persons in charge

The person in charge commenced their role in June 2025. The inspector found that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

On meeting and speaking with the person in charge on the day, the inspector found that they were familiar with the residents' needs and was striving to ensure that they were met in practice.

The person in charge was provided one month's handover from the previous person in charge to support them in their new role and become familiar with the organisation, the designated centre and the support needs of the residents. In addition, the person in charge was provided regular meetings with the senior manager, (PPIM) to support them in their role and ensure the effective governance, operational management and administration of the centre.

Judgment: Compliant

Regulation 15: Staffing

On review of the centre's actual and planned roster from October to December 2025, the inspector found that the person in charge had ensured that there was sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents living in the centre, on a daily and nightly basis.

Since the last inspection, there had been a reduction in staff vacancies, from 3.5 whole-time equivalent staff to 1.5 whole time equivalent. In addition a new full-time person in charge was employed in June 2025. Some staffing arrangements had also been adjusted that lead to positive outcomes for residents. For example, where five additional staffing hours were allocated on Saturday and Sunday, they had been amalgamated to provide ten hours on one of the weekend days. This meant that residents could now enjoy weekend community activities for longer periods at a time.

The person in charge was endeavouring to ensure continuity of care when managing

staffing arrangements. Where possible the core staff team worked additional hours to cover gaps on the roster. In addition, the same two to three relief staff and one agency staff, who primarily worked waking nights, covered the remaining gaps. The inspector was informed that the two relief staff members previously worked in the centre and were familiar to the residents.

Staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of supports in place to meet the residents' needs. The inspector observed kind, caring and jovial interactions between staff and residents throughout the day with residents appearing relaxed in the company of management and staff.

On the day of the inspection, the person in charge and person participating in management organised for staff records to be made available to the inspector in the designated centre for review. On review of a sample of eight staff files, including the person in charge's file (records), the inspector found that they contained all the required information as per Schedule 2 and appropriate vetting arrangements were also in place for staff files reviewed.

Judgment: Compliant

Regulation 16: Training and staff development

On review of the staff training records, staff 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 the resident. Staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of the supports in place to meet those needs.

Staff training records showed that staff had completed training in relevant areas, such as fire safety, safeguarding residents from abuse, safe medication management, positive behaviour supports, therapeutic interventions, and training in infection protection and control.

However, improvements were needed to ensure all staff training was up-to-date and particularly where staff were required to complete on-line training.

For example;

- Two staff were due on-line fire safety training,
- Three staff were due on-line safeguarding training,
- Three staff were due on-line open disclosure training,
- Three staff were due dignity in the workplace online training.
- Three staff were due to complete on-line training in feeding, eating, drinking and swallowing (FEDS).
- Five staff required in person manual handling training.

Three staff required first aid training however,they were booked on to a course in January and February 2026.

Since the last inspection, to better support a resident's assessed needs, a number of staff had completed training related to dementia care. However, four core team members and two relief staff had yet to complete the training.

There had been improvements to the area of staff supervision, and on the day of the inspection, the supervision schedule demonstrated that all staff supervision was up-to-date. In addition, a new storing and archiving system for supervision records had been implemented to ensure supervision records were stored and achieved correctly.

Judgment: Substantially compliant

Regulation 23: Governance and management

Since the last inspection, the inspector found that there had been significant improvements to governance and management systems in place 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.

A new person in charge had been appointed and commenced in their role in June 2025. Since commencing in their role, the person in charge attended meetings with the Service Manager (PPIM) and Director of Adult Services (PPIM), on a frequent basis, to monitor and give updates on the agreed actions from the centre's last inspection's compliance plan. .

The provider had completed an annual report of the quality and safety of care and support in the designated centre during 2024 and this was made available to residents and their families. In addition, since the last inspection, two six monthly reviews of the quality and safety of care and support in the centre, had been carried out during March and November 2025.

The person in charge was endeavouring to monitor, at local level all areas of service provision to ensure positive outcomes for residents. However, there was no comprehensive monitoring system in place for the person in charge to carryout out this task in an efficient and effective manner. The use of a 'monthly data report' had been queried on two unannounced six monthly reviews however, no follow up had taken place. While the inspector was informed that the data reports were not completed in all the provider's designated centres, the inspector found that no other effective local monitoring system was in place.

Improvements were also needed to ensure that there was sufficient resources in place that considered the time required for local management and staff to complete administration tasks as well as on-line training courses. From speaking with the

person in charge and staff on the day, the inspector was informed that one of the barriers to complete these tasks related to insufficient administration hours. Overall, a review of resources was required to ensure that management and staff were provided sufficient hours to complete tasks that better supported the needs of residents.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. The person in charge was ensuring that safeguarding was a standing item on the centres team meetings. On review of the most recent meeting, the inspector saw discussion and shared learning occurred regarding an recent safeguarding incident.

On review of records and notifications, the inspector saw that there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements. The person in charge ensured that incidents were notified in the required format and with the specified time frames.

Where it had been identified on the last inspection that a number of safeguarding incidents had not been notified, the notifications were subsequently submitted. In addition, a number of actions were completed that mitigated the risk of similar deficits occurring again. This is further discussed under Regulation 8: Protection.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had implemented satisfactory improvements that provided assurances that there were effective information governance arrangements in place to ensure that the designated centre comply with the notification requirement when there was a change or absence in the person in charge.

The appropriate notification was submitted when the new person in charge commenced in their role in June 2025. In addition, a staff member has been identified to support the person in charge with portal notifications.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

Since the last inspection, the provider had made improvements improvements so that there was an effective governance structure in place with clear lines of accountability for the delivery of a safe service, during periods when the person in charge is absent.

The service manager, person participating in management (PPIM) and director of adult Services (PPIM) have put systems in place that provided assurances that appropriate arrangements are in place for periods when the person in charge is absent. For example, a former social care leader joined the staff team in August on 2025. The inspector was informed that one of their duties was to cover during periods when the person in charge is absent and submit notifications as required when covering for the person in charge.

Judgment: Compliant

Quality and safety

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

Overall, the inspector found the centre was well run and provided a homely and pleasant environment for residents. Each of the resident's wellbeing and welfare was maintained by a good standard of evidence-based care and support. It was evident that the person in charge and staff members were aware of each resident's needs and knowledgeable in the person-centred care practices required to meet those needs.

The inspector observed staff engaging with residents and attending to their needs in a caring and professional manner. The inspector found that there had been a number of improvements to the quality and safety of service provided in the centre since the last inspection which had resulted in positive outcomes for residents.

In particular, improvements to fire safety precautions, premises and infection prevention and control resulted in residents living in a safer environment.

Residents living in the designated centre were protected by appropriate safeguarding arrangements. There was an up-to-date safeguarding policy in the centre and it was made available for staff to review. Staff were provided with appropriate training relating to keeping residents safeguarded.

There had been significant improvements to the infection, prevention and control measures in place. The inspector found that the infection, prevention and control

measures were effective and efficiently managed to ensure the safety of residents.

The provider and person in charge promoted a positive approach in responding to behaviours that challenge and ensured evidence-based specialist and therapeutic interventions were implemented. Systems were in place to ensure that where behavioural support practices were being used that they were clearly documented and reviewed by the appropriate professionals. There were restrictive practices used in this centre. The restrictive practices were supported by appropriate risk assessments which were reviewed on a regular basis to ensure that practices in place were the least restrictive, for the shortest duration necessary.

There had been significant improvement to the upkeep and repair of the premises and in particular, to the flooring and paintwork throughout the house. The inspector observed the premises to be clean and tidy and overall, presented as a homely and cosy environment to live in. The inspector observed that residents appeared to be comfortable and relaxed in their home surroundings. Some actions from the last inspection remained outstanding, such as upgrades to the kitchen and staff office.

The provider had ensured that the risk management policy met the requirements as set out in the regulations. Overall, there had been a number of improvements to the systems in place that manage and mitigate risks and keep residents and staff members safe in the centre.

There were a number improvements made to the fire safety systems in the designated centre which meant that residents were living in a safer environment. There were suitable means of escape and an up-to-date fire evacuation plan. A fire drill had taken place with the highest number of residents and lowest number of staff and staff had received suitable training in fire prevention and emergency procedures.

On review of a sample of residents' personal plans, the inspector found that the person in charge had ensured that there was a comprehensive assessment of need completed for each resident. However, support plans which guided staff members in supporting residents with identified needs and supports required improvement and in particular, the frequency of their review. .

The person in charge was endeavouring to ensure that residents received information in a way that they could understand. Residents communication needs were assessed on a yearly basis or sooner if needed. However, improvements were needed to ensure all residents were provided with an effective communication support plans. This was to ensure that there was appropriate guidance in place for staff on the best approach to use when communicating with residents. In addition, improvements were needed to ensure appropriate on-going professional input and oversight was provided to residents who required such support.

Regulation 10: Communication

The provider and person in charge were striving to ensure that residents were assisted and supported to communicate in accordance with their needs and preferences.

The residents living in this designated centre communicated using different means including spoken words, body language, facial expressions, use of pictures, photographs and social stories.

Residents were provided with an assessment of their communication needs on an annual basis and for the most part there were associated communication support plans in place to guide staff on how to meet the residents' assessed needs.

However, a review of the effectiveness of residents' communication support plans was needed so that they provided adequate, consistent and up-to-date guidelines for staff on how to engage with residents in a format that was of preference to them. In addition, improvements were needed so that, where required, all residents were facilitate to attend the appropriate multi-disciplinary professional to support them with their communication needs.

For example:

In one resident's assessment of need, there were a number of inconsistencies as to what type of supports they needed. In one part of their assessment it promoted the use of sign language, in another section, it noted that the resident did not engage with that form of communication. In addition, the resident's support plan noted that they used picture exchange system (PECS) however, on speaking with staff they advised that the residents did not use it in the centre. The resident's personal evacuation plan highlighted additional supports in place to support the resident process information however, this was not relayed in their communication support plan. The resident was facilitated to attend speech and language therapy (SLT) related to their feeding eating and drinking needs however, they were not provided this support in relation to their communication needs.

One other resident was provided with a communication aid support plan however, had no specific communication support plan in place. The communication aid plan which was due quarterly reviews, had not been reviewed since January 2025. A referral to the organisations SLT department had been made in March 2025 regarding the resident’s communication needs, however, there had been no response to date.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents living in the designated centre were facilitated and empowered to exercise

choice and control across a range of daily activities and to have their choices and decisions respected.

The person in charge and staff team assisted the residents to exercise their right to experience a range of relationships, including friendships and community links, as well as personal relationships.. Four of the five residents were attending adult day service in the community and one resident was receiving their day service from their home.

Since the last inspection, a number of improvements had been completed so that residents were provided meaningful and person-centre activities during the week and in particular for the resident who was not attending day service.

For example:

The local day centre co-ordinator carried out a review on the current day service provided to residents in the centre. A day service profile was completed for the resident and they were added to a waiting list. In the interim, a new day service timetable template was developed to ensure the resident was provided a choice of difference community activities on a daily basis

On the day of the inspection, the inspector observed, that the timetable noted that the resident was due to go bowling. The person in charge informed the inspector that the resident had enjoyed bowling for several weeks however, had since changed their mind and was no longer keen to attend this activity. The inspector was informed that there was a plan to review and update the timetable so that it reflected current activities the resident enjoyed.

On speaking with a staff member, they told the inspector about a new community activity that the resident was enjoying taking part in. The resident had joined a 'ladies' group' that involved regular meet ups other female friends from other designated centres. The group enjoyed part-taking in different activities as a group and developing their relationships. The inspector was informed that this activity was meaningful to the resident as they enjoyed other people's company, going to cafes and listening to other peoples' news.

Improvements were also made to the staffing arrangements to facilitate the resident's day service hours. For example, two staff were rostered to work during the day time so that there was always one staff was available to the resident during their day service hours.

Judgment: Compliant

Regulation 17: Premises

Since the last inspection, there had been significant improvements made to the premises which saw positive outcomes for residents in terms of their safety and

wellbeing.

New flooring had been installed throughout the halls, landing and a number of rooms in the centre. The walls of the centre as well as most residents' bedrooms had been painted. One resident who showed the inspector their bedroom expressed their happiness at their newly painted pink walls and of their bedroom's new timber flooring. Overall, the improvements to the premises reduced the previous identified infection prevention and control risks and ensured residents were living in a safer environment.

However, some works remained outstanding. The planned replacement of the kitchen or works to staff office flooring had not been completed. In addition, the inspector observed that the counter tops and cupboards in the laundry room were in poor upkeep and repair. The inspector was informed that the kitchen and office works were due to be completed in 2026 however, as of the day of the inspection, there was no date or time line in place for the works to commence.

Notwithstanding the above, overall, the physical environment of the house was clean and for the most part, in good decorative and structural repair. The design and layout of the premises ensured that each resident could enjoy living in an accessible, safe, comfortable and homely environment. This enabled the promotion of recreation and leisure and enabled a good quality of life for the residents living in the centre.

The house was found to be suitable to meet residents' individual and collective needs in a comfortable and homely way. Residents expressed themselves through their personalised living spaces and were consulted in the décor of their rooms which included family photographs, paintings and memorabilia that were of interest to them. One resident who showed the inspector their room expressed their contentment at the new blue colour their walls were painted and informed the inspector that they had picked out the colour.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

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

Where there were identified risks in the centre, the person in charge ensured appropriate control measures were in place to reduce or mitigate any potential risks. Since the last inspection, there had been an number of improvements to the measures in place for risks associated with fire safety, lack of adequate leadership, staff supervision and oversight of the centre and high turnover of persons in charge in the centre. All of the measures resulted in a safer and more consistent service for

the residents.

The person in charge had completed a range of risk assessments with appropriate control measures that were specific to residents' individual health, safety and personal support needs. There were also centre-related risk assessments completed with appropriate control measures in place.

There was good oversight of risks in the centre. The person in charge carried out quarterly reviews and updates on the risk register and associated risk assessments. The risk register and associated risk assessments were reviewed in February, May and October 2025 and included updates and additions where necessary.

Judgment: Compliant

Regulation 27: Protection against infection

The inspector found that, for the most part, the infection prevention and control measures were effective and efficiently managed to ensure the safety of residents living in the centre.

There had been improvements made in the centre since the last inspection some of which include:

- As mentioned in Regulation 17: Premises, the provider had organised for upkeep and repair works to the floors and wall of most areas of the residents' home that reduced the risk of spread of infection.
- Risk assessments were put in place for ongoing premises and infection prevention and control issues and are reviewed on a quarterly basis.
- The cupboards in the laundry room were observed as clean and since the last inspection, underwent a deep clean.
- New mop heads and buckets were purchased and stored in an appropriate location.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured that all action from the last inspection relating to fire safety were completed. This mean that the fire precautions systems in place ensured each resident's safety.

Some of the following improvements were observed in place:

- All evacuation plans were reviewed, and updated where required in

consultation with the organisation's fire officer.

- A fire drill with five residents and one staff was completed in March 2025.
- The sitting room fire door issue was rectified in April 2025 with one resident's fire evacuation plan updated to reflect this.
- To ensure appropriate oversight, all fire training drills with the fire officer will be logged on the organisation's eform system.
- A new handover template has been implemented for relief and agency staff, which highlights the fire evacuation for the centre and other associated risk.
- The evacuation plan is in the emergency file which any unfamiliar staff is provided with for reference if needed.
- Fire safety and evacuation is discussed weekly with residents at residents' meetings.
- A ramp was fitted to a fire exit door in April 2025 to allow ease of access for evacuation.

However, some additional improvements were required to ensure the provider's containment measures were not impacted by the placement of objects or furniture.

The inspector observed that the layout of the furniture in a resident's room and the use of a door stopper was impacting on the effectiveness of the electronic door closing device. The person in charge advised the inspector that the layout of the room was in line with the resident's preference and that, on an ongoing basis, staff were encouraging the resident to refrain from placing objects to hold the door open.

To ensure the safety of the resident, improvements were needed to so the most effective fire safety arrangement to contain and mitigate the spread of smoke and fire was in place whilst also supporting the resident's preferences.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

On review of a sample of three residents' personal plans, the inspector saw that there was an assessment of need in place for residents, which identified their health, personal and social care needs.However, on review the inspector saw that they were not reviewed in line with the provider's policy.

For example, where a resident's assessment of need was reviewed in March 2025, there had been no review of the associated support plan since that time. In line with the provider's policy, residents' support plans were due review on a quarterly basis. For example, supports plans that related to the resident's medication, personal care, personal safety, toileting, dental cardiology and pain management, had not been reviewed since March 2025.

In another resident's assessment of need that was reviewed in February 2025, the inspector observed supports plans that had not been reviewed since August 2024.

In addition, support plans implemented in February 2025, had only been provided with a review in May 2025 with no further review since. Some of these plans included, the resident's emotional support plan, general health plan, intimate care plan and community safety plan.

A new monthly keyworker checklist had been implemented since the last inspection to ensure improvement to oversight to the reviews of the plans. However, the inspector found that in one resident's plan, the checklist had not been completed, in another resident's plan it was completed for March 2025 with no other monthly checks since that time, and in another resident's personal plan the checklist had not been put in place.

Since the last inspection, a new goal tracker sheet had been implemented as a way of effectively monitoring the progress of residents' goals. However, on review of one resident's tracker, the inspector found a number of gaps. There were other goal related documents within the resident's plan describing goals the resident had chosen. However, as there was no date on them it was difficult to ascertain when the resident chose the goal and when it was last reviewed. Where there were dates on these forms, the progress of goals ranged from January 2024 to February 2025 with no progress noted since that time.

Overall, the inspector found that due to the ineffective reviews of residents' personal plans, the provider could not be assured that residents' current assessed needs were being fully met or supported adequately. In addition, a review of the newly implemented checklists and trackers of residents' plans was required to ensure their effectiveness in supporting the resident with their health, personal and social care needs.

Judgment: Not compliant

Regulation 8: Protection

Overall, the inspector found that the provider and person in charge had ensured that there were appropriate systems in place to safeguard residents from abuse.,

On speaking with the person in charge and on review of documentation, the inspector saw that a number of improvements had been made since the last inspection.

For example:

- A safeguarding audit completed in April 2025 and all actions from the plan were complete.
- Safeguarding was included as a standing agenda item at all staff meetings. On review of the most recent meeting in October, the inspector saw that a recent safeguarding incident had been discussed to provide shared learning in the team.

- In May 2025, the organisation's designated officer provided training to the staff team on the organisation's safeguarding policy and how to complete the forms required when reporting a safeguarding incident .
- A new local financial policy was implemented and all staff were made aware of it.

In addition, the training records demonstrated that all staff had been provided training in Safeguarding of vulnerable adults and Children's first and for the most part, all was up-to-date. .

From reviewing all staff files with regard to Schedule 2 of the Regulations, the inspector saw that staff members had appropriate Garda vetting in place.

Information on how to contact the designated officer was on display in the centre as well as information on how to make a complaint.

The person in charge understood their role in adult protection and was knowledgeable of the appropriate procedures that needed to be put into practice when necessary and overall, were aware of the policies and procedures in place relating to safeguarding.

The provider and person in charge had put in place safeguarding measures to ensure that staff providing personal intimate care to the resident, did so in line with each resident's personal plan and in a manner that respected their dignity and bodily integrity.

Where there had been a safeguarding incident the inspector reviewed records that demonstrated that the person in charge had followed up appropriately and ensured that they were reviewed, screened, and reported in accordance with national policy and regulatory requirements. Following on from the incident, risk assessments were reviewed and updated and safeguarding plan implemented. The person in charge informed staff about the plans through communication book and at the most recent staff meeting.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for 49 Rathbeale Road OSV-0002393

Inspection ID: MON-0047831

Date of inspection: 01/12/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In response to Substantially Compliant under Regulation 16 (1) (a), the following actions have been taken: • 5 staff booked for Manual Handling 3rd and 11th of February 26. • 3 staff booked for Emergency First Aid 21st January 26. • 2 staff booked for Positive Behaviors Support Training (Awaiting date). • All staff will have completed all online training by the end of January 26. • PIC will request the Training Department for further Dementia Training to be booked by the first quarter of 2026.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In response to Substantially Compliant under regulation 23 (1) (a): • Going forward the PIC will allocate time on the Roster for staff to complete	

administration tasks or training to better support the needs of Residents.

In response to Substantially Compliant under regulation 23 (1) (c):

• The PIC completed training on the Role of the PIC and Roster Management on 16/7/25.

• During Induction the PIC was given a comprehensive annual monitoring system that was utilized in another residential house

• The PIC has reviewed and modified this system to suit Rathbeale Road.

• Local Monitoring takes place at Management Meetings, Probation Meetings and the PIC has been involved in PIC Forums, Cluster Meetings and a comprehensive range of Training to inform him of the all the responsibilities in the PIC role.

• Whilst not a regulatory requirement the PIC, as of January 2026, will complete Monthly Data Sheets.

• The Service Manager will request a roster review in the first quarter of 2026 to review administration hours for PIC.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
In response to Substantially Compliant under regulation 10 (1):

• The PIC will request SLT to do a site visit and review the effectiveness of each Resident's Communication Support Plan.

• Key-workers will review the Assessment of Needs of the 2 people identified in the Report and will liaise with the SLT team in relation to the effectiveness of the Communication Support Plans.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In response to Substantially Compliant under Regulation 17 (1) (b):

• The replacement of the kitchen is part of the Maintenance Work Plan for 2026. • The Service Manager requested a date of completion from the Director of Estates. A completion date will be forwarded to the Authority when available. • The PIC will submit a request to Maintenance Dept for an upgrade of the counter tops and cupboards in the laundry room.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: In response to Substantially Compliant under Regulation 28 (1):

• The PIC consulted the Fire Officer in relation to the concern raised by the Inspector.

• The PIC removed the door stopper in the Resident's bedroom.

• On an on-going basis the Resident is reminded of the importance of good fire safety practice and has been offered alternative options for the placement of his chair in his bedroom.

• The PIC checked the effectiveness of the electric door closing device in the Resident's bedroom and found it to be correct and effective.

• The Fire Officer visited the house on 16/12/25 to provide Training with all staff which included going through the fire evacuation for all Residents in the house. The Fire Officer also went through the equipment and how to use it appropriately.

• All staff have completed Fire Safety Training.

• 2 fire drills are carried out each year, 1 day time (completed on 31/3/25) and 1 nighttime (completed on 16/12/25).

• Additional Fire Walks are carried out with Residents and new or Agency Staff to help them understand the importance of fire safety.

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: In response to Non-Compliance under regulation 5 (6) (c): • The PIC has allocated hours for all Keyworkers in January 2026 to review Assessment of Needs and update all relevant documentation. • A new monthly Keyworking Checklist is in place whereby Keyworkers report monthly on each Residents progress and discuss at the Staff Meeting. • Going forward the PIC will ensure that staff are completing and updating this Checklist. • The Staff Team had training on PCP planning 20/8/25, where they discussed the process of creating goals and keeping records up to date. • The PIC will ensure that Keyworkers are updating the Goal Tracker Sheet. • The PIC will include the Keyworking Checklist and Goal Tracker as part of the Supervision Agenda with staff. • Keyworking Checklist and Goal Tracker will be included as part of the Staff Meeting to discuss progress. • The Service Manager will discuss progress in this area with the PIC in Management Meetings	

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/03/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/03/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and	Substantially Compliant	Yellow	31/12/2026

	internally.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/01/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2026
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/01/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/03/2026