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:	Announced
Date of inspection:	26 March 2025
Centre ID:	OSV-0002393
Fieldwork ID:	MON-0037558

About the designated centre

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

49 Rathbeale Road is a designated centre operated by St Michael's House located in North County Dublin. It provides a community residential service for up to five adults with a disability. 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 also responsible for one other designated centre and divides their time between both centre. 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
Wednesday 26 March 2025	10:15hrs to 18:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This announced inspection took place over the course of one day and was to monitor the designated centre's level of compliance with S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations). It was also to inform a decision on the renewal of the registration of the centre.

There was a significant decline in compliance in the centre since the last two inspections which was overall posed a safety risk to residents living in the centre. Numerous changes of person in charge, as well as the procedures and arrangements in place during these changes, had impacted negatively on the consistency and effectiveness of monitoring systems in place. This was impacting on the safety of residents living in the centre and on the day of this inspection a number of risks were identified and in particular, fire safety risks.

The person in charge facilitated the inspection by speaking with the inspector and endeavouring to provide any requested documentation. The designated centre provided full-time residential care and support to five adults with intellectual disabilities.

Observations and interactions with residents, in addition to a review of documentation and conversations with key staff, were used to form judgments on the residents' quality of life.

Residents living in the centre used different forms of communication. The majority of residents living in the centre used and understood verbal communication however, where appropriate, their views were relayed through staff advocating on their behalf. Residents' views were also taken from the designated centre's annual review, Health Information and Quality Authority's (HIQA) residents' surveys and various other records that endeavoured to voice residents' opinions.

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.

The inspector was provided the opportunity to meet and speak with four residents on the day. One of the residents showed the inspector their bedroom. The inspector observed that there was a lot of items in the room that were personal and important to the resident however, as there was so many items in the room a review of the storage systems in place was needed. The person in charge informed the inspector that staff were supporting the resident to try and reduce the build-up of items in their room so that it was less cluttered and overall, a safer environment to sleep in.

Later in the afternoon the resident showed the inspector around the rest of the house. The inspector observed that the resident seemed comfortable and relaxed in their environment when doing so. Near the end of the inspection the same resident spoke with the inspector and relayed some of their views.

They told the inspector that they liked most of the staff working in the centre and the new person in charge. However, they expressed their unhappiness about two staff . They told the inspector that everyone was assigned a day to use the laundry facilities. Friday was their laundry day however, they said they were not happy about two staff who also used the laundry to wash other residents clothes on this day also. The inspector asked the resident if they had raised this issue with the person in charge or any staff. The resident said they had not. The inspector followed up with the person in charge who said they had planned to provide additional training regarding the complaints process to staff. This was to ensure that residents were empowered and supported to raise any issues or complaints they may have.

During the day, two residents attended day service and on return from their service one resident showed the inspector their bedroom. They seemed happy and proud to show their room to the inspector and pointed out family photographs and football club posters that hung on their wall. The inspector was advised that one of the resident's goals was to visit the place of their favourite football club.

During the inspection, the person in charge accompanied the inspector during an observational walk-around of the centre. Not all areas of the house were observed at that time however, as mentioned above, a resident showed the inspector around the other areas of the house.

Overall, the inspector observed that the staff team, in line with residents' wishes and likes had made the centre to appear welcoming and homely. For the most part it was observed as clean however, due to poor upkeep and repair in some areas of the house, cleaning was not always effective in ensuring an hygienic environment.

The centre comprised of a detached dormer bungalow with a garden to the front of the house that included an outside seating area and benches to the back of the house. Inside the premises there were two sitting rooms - one was part of the open plan area and was warm and cosy. The other sitting room was a small relaxing area for residents to spend time alone if they wished. The inspector was informed about one resident in particular who enjoyed the room and about a plan in place to put a television in to the room for them. The large open plan kitchen with a dinning area. A number of areas in the kitchen were observed to require upkeep and repair and in particular, areas over the cooker hob and counter tops.

Each resident was provided their own bedroom and these were laid out in line with resident’s wishes and preference. Bedrooms included individualised soft furnishings, memorabilia, pictures, family photographs which were in line with each resident’s likes and preferences. In line with one resident’s likes and preference, their room was observed to contain very little personal items and present as minimalistic in design.

The staff office had recently been moved downstairs and this was to support supervision of residents in line with their changing needs. The floor in the office and ground floor hallway of the house was in need of upkeep and repair to ensure the effectiveness of IPC measures in these areas. The inspector was informed that one of the residents like to mobilise in a seated position on the floor. This meant that there was a risk of spread of infection to the resident as the floors could not be effectively cleaned.

There was a spare room upstairs that was previously a staff sleepover room. The inspector observed the room to be cluttered with a lot of items inappropriately stored in it. There were two shared bathrooms in the house that required some upkeep and repair. The utility room contained laundry facilities including a washer, dryer and cupboards containing laundry related items as well as PPE equipment. However, improvements were need to the cleanliness of the cupboards as well as the sink and draining area.

In advance of the inspection, residents were each provided with a Heath Information and Quality (HIQA) survey, where they could relay what it was like to live in their home. Three residents chose to complete the surveys with the support of a staff member. Overall, the surveys relayed positive feedback regarding the quality of care and support they were in receipt of. The surveys indicated residents' satisfaction with activities, trips and events, having their say, staff support and food provided.

Family feedback about the service was very positive. The provider's annual review of 2024 which was completed in March 2025 noted some of the comments made by families: "I'm grateful my family member lives in Rathbeale Road"; "I would be lost without the staff of Rathbeale Road"; "The staff are so helpful and approachable"; "The staff are always thinking about different ways to support the different needs of the residents"

Staff who spoke with the inspector were familiar with residents' assessed needs and supports in place to meet those needs. They were aware of each resident's likes and dislikes. They were also aware of the approaches to support residents when they were feeling anxious or displaying behaviours that could impact on other residents. Staff who spoke with the inspector also relayed their concern at the lack of leadership and supervision in the centre over the past number of years. They said that while they were endeavouring to keep up with some of the local monitoring checks and systems, it was hard due to the changing needs of residents, staff shortages and overall the time required to support residents' needs, which overall took priority for them.

Residents were provided weekly house meetings where the agenda included topics such as menu planning and weekly activities. Other items were raised from time to time such as hand-hygiene, national celebrations days, resident's birthdays and plans, road safety and fire safety, but to mention a few.

For the most part, residents were facilitated to exercise choice across a range of therapeutic and social activities and to have their choices and decisions respected.

Four of the residents attended a community day services. However, where one resident attended a day service from their home, the inspector found that improvements were needed to ensure that they were provided meaningful activities in the community to promote positive outcomes for the resident in terms of the their wellbeing and development.

In summary, the inspector found that the new person in charge and staff team were endeavouring to ensure that each resident's well-being and welfare was maintained to a good standard. However, due to the poor governance and management arrangements in place in the centre over the previous two years and in particular, the high turnover of persons in charge, the service being delivered to residents was not ensuring their safety at all times. The provider had not ensured that the systems in place in the centre were consistent or effective at all times and this was impacting on a number of areas relating to the quality and safety of the service delivered to residents living in this centre.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and to contribute to the decision-making process for the renewal of the centre's registration. 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 inspector found that overall, the provider had not ensured that comprehensive arrangements were in place to assure itself that a safe and good quality service was being provided to residents living in the designated centre.

The inspector found that since the last inspection, there had been a significant drop in compliance which was primarily due to ineffective oversight and monitoring systems at provider and local level. Eight regulations were found non-compliance including notification of incidents, notification when a person in charge is absent, procedures and arrangements in place when a person in charge is absent, governance and management, staffing, risk management and fire precautions. The later regulation was issued an urgent action, seeking assurances from the provider to ensure the safety of residents in the event of a fire outbreak. Subsequent to the inspection the provider submitted a compliance plan that provided assurance of a number of actions to be completed to reduce the safety risk to residents.

Over a period of two years there had been six changes to the person in charge. During these times, the inspector found that the provider had not ensured that there were effective leadership or governance and management systems and structures in place. They had not ensured clear lines of accountability at individual, team and organisational level so that all staff working in the service were aware of their responsibilities and the reporting structures.

The number of changes to the role of person in charge in the centre was impacting on the consistency of service delivery. In addition, the arrangements in place during times the person in charge was absent or changed, was not adequate and meant that a number of risks related to residents' safety had not been identified. Staff were endeavouring to keep up with daily, weekly and monthly checks in the centre as much as they could however, their capacity was limited as their priority was ensuring good quality frontline care and support was provided to residents.

The inspector found that, as a result of the number of changes of person's in charge, the governance systems in place in the designated centre had failed to ensure that service delivery was safe. Provider and local auditing systems in place, that monitored the centre's performance, were not effective in ensuring a quality assurance system was in place. In addition, the changes in person in charge were impacting negatively on the operational management and administration of centre and were not ensuring safe and effective service delivery to residents at all times..

Improvements were needed to ensure that appropriate staffing levels were in place to meet the assessed needs of all residents, all of the time. There were vacancies in the centre and where they were covered by less than permanent staff, consistency of care had not been ensured. There had been changes to staffing levels without due consideration of the risks and impacts these changes may have on residents' lives in particular, in terms of safety.

Adverse incidents and accidents in the designated centre, required to be notified to the Chief Inspector of social services, had not been notified, at all times, within the required time frames as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

Registration Regulation 5: Application for registration or renewal of registration

The application for registration renewal and all required information was submitted to the Office of the Chief Inspector within the required time-frame.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge divided their role between this centre and one other. According to the notification submitted to the chief inspector, the person in charge had commenced in their role in this centre in 31/01/2025. The person in charge was supported by the provider and person participating in management (senior service manager).

The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs. They were also aware of their legal remit to S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

During the short period the person in charge had worked in the centre the inspector found that they had made some improvements to the operational and administration of the centre. They worked on-site in the centre two days a week and were available to staff should they have any issues. Staff who spoke with the inspector commented positively about the support the person in charge provided during this time and in particular, of their on sight presence and leadership.

The person in charge was the seventh person in charge in the centre within the last two years. On the day of the inspection, the person in charge (and staff) were unaware if they were the permanent or interim person in charge. At feedback, at the end of the inspection, the service manager advised the inspector that the new person in charge's role was interim and the provider was currently looking to recruit a person in charge.

Overall, the provider had not ensured that effective contingency for leadership and succession planning were in place each time there was a change in person in charge or where an interim person in charge was in position. Where previous person's in charge were also responsible for other centres as well as this centre, this had negatively impacted on governance, operational management and administration of the centre. This is discussed further in regulation 23, 32 and 33.

Judgment: Substantially compliant

Regulation 15: Staffing

The designated centre’s statement of purpose stated that there were 3.3 whole time equivalent (WTE) vacancies in the centre. The vacancies were being covered by permanent staff working extra shifts as well as agency and relief staff. During times relief staff were employed a permanent staff was rostered to work with them. This was because relief staff were not permitted to administer rescue medicine, if it was required.

On review of staff feedback recorded in the provider’s Annual report of the quality of care and support provided to residents, it was noted that a challenging area for the centre was staff vacancies in 2024. The feedback noted that “staff have felt it challenging working with relief and agency and noted that the residents prefer to work with staff who know them well”.

On the day of the inspection there was uncertainty about the number of actual vacancies. The inspector was informed that a review of staffing levels was due to take place on 11th of April 2025. However, in advance of the review there had been

changes to the roster such as reduction in staffing levels and reduction in continuity of care.

On observing the roster for January, February and March 2025 the inspector saw residents were supported by three staff at weekends, however, the April 2025 roster showed a reduction to two staff on Saturdays and Sundays. For example, the 12 – 6pm shift was removed on both days. During the week three residents attended day service, one resident was provided on-site day service and one resident stayed at their family home (Tuesday to Thursday). However, during the Saturday and Sunday, where there was no community day service, for the most part, five residents lived in the designated centre. There had been no risk assessment or measures put in place to ensure that the change in staffing level, with higher numbers of residents and lower numbers of staff, was safe or how it would impact on the quality of residents' lived experience during these times.

The inspector was informed that resources had not been approved for the extra week-end shifts and as such there was currently no funding in place for staff to work these shifts. These arrangements potentially impacted on residents accessing meaningful community activities at weekends which overall had the potential to impact negatively on the lived experience of residents.

An agency staff nurse had been employed to cover some of the staff vacancies. On review of the January to February 2025 roster, the same agency staff nurse was covering the majority of the waking night shifts. For example, between January and February they worked 15 nights. During this period, the staff member had become familiar to the residents. These arrangement were also promoting a level of continuity of care to residents. However, on review of the roster from early March to April there was an increase in the number of different staff covering these shifts. The inspector was informed by the person in charge and staff that the cost of employing staff from that particular agency service was too expensive to maintain. Staff from another agency service were now being employed.

Both of these situations demonstrated that overall, staffing levels and cover had not been planned effectively or in a safe manner and was likely to impact negatively on residents' lived experiences, preference for familiar staff and overall, the continuity and quality of care and support in the centre.

Furthermore, due to the numerous changes of persons in charge (seven in the last 24 months) the provider was not ensuring continuity of staffing, at management level and contingency for leadership and succession planning had not been adequately considered and had impacted on the safety of residents living in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

There had been improvements to staff training since the new person in charge commenced their role in 2025. The inspector reviewed the centre training matrix which showed that staffing training was previously at 65% compliance level however, was currently at 95%.

On review of the training schedule, the inspector saw that most staff training, as well as refresher training, was now up-to-date. This meant that for the most part, staff were provided with training to ensure they had the necessary skills and knowledge to respond to the needs of residents.

For example, staff had undertaken a number of training courses, some of which included the following:

Feeding eating and drinking and swallow (FEDS)

Manual handling

Fires safety

Diabetes training

Food Safety

Safe medication management

infection prevention and control

Safeguarding vulnerable adults.

However, some improvements were required and in particular, to ensure that staff were provided with training that was in line with all residents' assessed needs. For example, training in dementia care. The person in charge told the inspector that they had identified this training deficit and was planning to secure training for staff. The person in charge had also identified that staff required positive behaviour support training and had booked a course for seven staff members.

One to one supervision meetings, that support staff in their role, when providing care and support to residents, were not being completed in line with the organisation's policy. On speaking with two staff members, the inspector was advised that they had not received any one to one staff to manager supervision meetings during the last year.

On commencement of their role, the new person in charge had not been provided with information regarding any other staff receiving one to one supervision meetings during the last year. In addition, there was no documents available to the inspector on the day to provide evidence that any staff member had been provided with this support.

Judgment: Substantially compliant

Regulation 21: Records

On the day of the inspection, the person in charge organised for staff records to be made available to the inspector in the designated centre for review. On review of a sample of five staff files (records), the inspector found that they contained all the required information as per Schedule 2.

With regard to Schedule 4 records, where there were deficits under Fire Safety records, these have been addressed under regulation 28.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had valid insurance cover for the centre, in line with the requirements of the regulation.

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre.

The inspector reviewed the insurance submitted to HIQA and found that it ensured that the building and all contents, including residents' property, were appropriately insured. In addition, the insurance in place also covered against risks in the centre, including injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that a review of the quality and safety of care and support in the centre, to measure the service's performance against the national standards, and to identify any areas for ongoing improvement, had been completed on an annual basis, as required by the regulations. The most recent review was completed in March 2025 of service provision in 2024, however, there had been no review completed of service provision in 2023.

In the 2025 review, staff had been consulted and fed back that they felt a full-time present of a person in charge was required to ensure continuity of care and provide leadership on a consistent basis.

Six monthly unannounced reviews of the quality and safety of care provided to residents was not always in line with the requirement of the regulations. For example, the unannounced visit in August 2024, took place eight months after the previous visit in December 2023.

On review of the local monitoring system in place the inspector found that there was no documented evidence to demonstrate that monthly health and safety audits, safe medication management audits had been completed. On speaking with the new person in charge, they were unable to locate such audits. Fire safety audits from July 2024 to January 2025 were shown to the inspector. However, as they had not included actions for any of the fire safety issues that had been identified on the day of the inspection, they were not ensuring quality improvements were taking place.

The provider had failed to ensured that all staff were provided supervision supports in line with the organisation's policy. As such, staff were not provided the opportunity to engage in a supportive system that aimed to support to them perform their duties to the best of their ability.

The provider had not ensured that the centre was appropriately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. The statement of purpose noted 3.3 whole time equivalent staff vacancies however, on the day the person in charge was unsure of the number of vacancies. A review of staff requirements was due to be completed on the 11th of April. This meant that at the time of the inspection, the provider could not be assured that the number, and skill mix of staff was appropriate to the number and assessed needs of residents living in the centre.

The provider had not ensure that appropriate and effective fire safety management systems were in place in the centre. The provider was issued an urgent action due to the high level of risk identified on the day of inspection, relating to the safety of residents. (This is addressed further under regulation 28)

The provider had failed to ensure that there were effective systems in place for the assessment, management and ongoing review of risk. On the day of the inspection, there were a number of risks identified relating to fire, infection prevention and control, staffing and oversight and leadership that had not been identified by the provider. In addition, where risk assessments were in place the provider had not ensured their ongoing review. This is addressed further under regulation 26.

The information governance arrangements in place to ensure that the designated centre complied with notification requirements were not effective. For example, the provider had not submitted notifications relating to safeguarding, restrictive practices, non-serious injuries and changes in the person in charge within the appropriate timeframes or in compliance with S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations).

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose as part of the registration renewal document requirement.

The statement of purpose included all the items required as per schedule 1.

There was a copy of the statement of purpose in the house and was available to residents and their representatives.

Judgment: Compliant

Regulation 31: Notification of incidents

The information governance arrangements in place to ensure that the designated centre complied with notification requirements were not effective at all times.

For example; where there had been an allegation of abuse raised on 9th of March, this had not been notified to the Chief inspector until the 19th of March (seven working days over-due). This had also resulted in the delay of screening and investigation of the incident which meant there was a delay in ensuring appropriate safeguarding measures were in place to mitigate the risk of the concern happening again. This is discussed further under regulation 8.

In addition, a quarterly notification relating to occasions of which restrictive procedures were used in the centre was not submitted to the Chief Inspector for quarter four of 2024. On speaking with the person in charge, it was unknown if a quarterly notification relating to non-serious injuries was also due. The person in charge had yet to review documentation and body charts that would provide this information.

Judgment: Not compliant

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

The provider had failed to ensure that there were effective information governance arrangements in place to ensure that the designated centre complied with the notification requirement when there was a charge or absence in the person in charge.

Since March 2023 to date, the provider had submitted five NF30s regarding absence or changes in the role of the person in charge however, they were not submitted in compliance with S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations).

The provider had failed to notify the Chief Inspector of all periods where the person in charge had changed and had not submitted all notifications within the required timeframes. For example;

On three occasions during 2024, the provider submitted late notifications (NF30) for changes in persons in charge that occurred during 2023.

The notification (NF30) that was submitted for the most recent change in person in charge, was inaccurate. For example, it noted that the previous person in charge had ceased in the role at the end of January 2025. However, on the day of the inspection, the inspector was informed that they had ceased the role in July 2024.

The inspector was informed of the name of staff member who was assigned the role of person in charge during the later quarter of 2024, however the provider had failed to notify the Chief Inspector of this. There was no evidence submitted to HIQA to demonstrate if the person had the appropriate qualifications and management skills to ensure effective governance, operational management and administration of the designated centre.

On one occasion, the provider had submitted a notification (NF30) for a person in charge that did not comply with regulation 14. For example, the person did not have the required health and social care management qualification that was required to be in compliance with the regulation.

Judgment: Not compliant

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

The provider failed to demonstrate that they were familiar with the notification requirements. While at times, they notified the Chief Inspector of the procedures and arrangements for periods when the person in charge was absent/changed, the arrangements put in place were not adequate. The inspector found that the service had not been properly managed during the periods of ongoing changes in persons in charge and had failed to ensure that there was an effective governance structure in place with clear lines of accountability for the delivery of a safe service.

The inspector found that on speaking with staff, through observations and on review of documentation such as safety checks, audits and oversight records, that there was a lack of clearly defined lines of authority and accountability in place. In

addition, effective leadership and management that ensured appropriate delegation when necessary, was also lacking.

The inspector was informed by staff that not all previous persons in charge were based on-site in the designated centre and that their main point of contact to their manager was through a telephone call.

On speaking with staff on the day, they told the inspector that they were not aware if the current person in charge was working on a permanent basis or interim basis. On speaking with the currently person in charge, they were also unaware of the duration of their role in the centre. The poor planning and succession of the role of the person in charge was resulting in a lot of uncertainty in the centre.

The inspector found that staff had endeavoured to maintain a level of accountability in the centre through local audits and checks however, due to their front line care and support responsibilities to meeting residents assessed needs, this was proving unsustainable. Staff who spoke with the inspector informed them that there was a pattern of a "step in person in charge" in the centre and that there was a lack of leadership of the service. The said, at times, there was nobody to delegate tasks. One staff informed the inspector of how staff strived to manage issues arising from being short staffed. They said that during these times they often arranged to switch shifts so that all shifts were covered and included one permanent staff on duty during the day however, this had proved difficult at times.

Overall the inspector found that leadership, supervision and support for staff during the changes of persons in charge was lacking and overall had resulted in the provision of a service that was not safe at all times, in particular, in relation to fire safety, identifying risk and ensuring continuity of staffing to meet the needs of residents.

Judgment: Not compliant

Quality and safety

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

The provider had failed to put adequate measures in place to ensure that a safe and quality service was delivered to residents. The findings of this inspection demonstrated that overall, the provider was not ensuring that they were operating the service in compliance with the regulations and in a manner that ensured the delivery of safe and consistent care to residents. Significant improvements were needed to a number of regulations relating to the quality and safety of service provided to residents to ensure they were in compliance with the regulations for example, risk management, fire precautions and infection prevention and control.

Improvements were also required to the areas of assessment of need and person planning, general welfare and development and protection.

The inspector reviewed residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs and that overall, staff were endeavouring to ensure that arrangements were in place to meet those needs. Residents were consulted on and were part of an annual review of their plan. Residents and people who were important to them, were consulted throughout the review and new goals were set. However, some improvements were needed to effectiveness of the review of personal plans and in particular, in relation to residents' personal goals.

The inspector reviewed the centre's risk management policy and found that the provider had ensured that the policy met the requirements as set out in the regulations. The copy of the policy submitted to the Chief Inspection in advance of the inspection, showed that it had been last reviewed in June 2023.

However, a number of improvements were needed to the effectiveness of the risk management systems in place to ensure the safety of staff and residents at all times. This was to ensure that all risks were identified and provided measures to mitigate the risk. Improvements were also needed to ensure that risks were reviewed on a regular basis so that where changes or issues had occurred, that these had been accounted for and appropriate measures put in place.

The provider had failed to ensure that there were effective fire safety management systems in place in the designated centre. Overall, a significant number of improvements were needed to ensure the effectiveness of the fire precautions in the centre to ensure residents and staff safety at all times.

There was an up-to-date safeguarding policy in the centre and it was made available for staff to review. Staff had been provided in training in safeguarding venerable adults and training in this area was up-to-date. There were procedures were in place, which included the development of personal and intimate care plans, and support from a designated safeguarding officer within the organisation. However, improvements were needed to some of the practices in place in relation to safeguarding. In particular, in ensuring all incidents or allegations of safeguarding concerns were reported in a timely manner and in line with national policy and best practice.

Improvements were needed to the upkeep and repair of number of areas to the internal areas of the house. This was impacting on the effectiveness of infection prevention and control measures in place and in particular, in terms of ensuring the centre was cleaned in a way that mitigated the risk of spread of infectious decease. While, the works required had been reported to the maintenance department in February 2025, there was no plan or timeline to complete the works. This was of particular concern where a resident regularly mobilised in a seated position around different areas of the house.

Regulation 13: General welfare and development

On review of personal plans, surveys, feedback from the provider' annual report and speaking with staff, the inspector found that most of the 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 inspector found that, for the most part, residents were assisted 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.

In addition, residents were engaged in their local community through many different social activities including clubs, swimming classes, attending local concerts and musicals, going to local cafes and restaurants and enjoying outdoor parks and centres.

However, where a resident was provided a day-service from their home, the inspector found that improvements were needed to ensure they were provided meaningful and person-centred activities during the week.

The inspector was informed of concerns that the resident was not getting the opportunity to engage in daily activities that were in line with their likes and preference or that ensured meaningful community participation. The issue had been raised at staff meetings on several occasions. A daily activity tracker had been created and put in place to ensure daily activities were provided and were recorded when they took place.

On review of the tracker for January to March 2025, the inspector found that there were a lot of gaps in tracker. For example in March, the tracker demonstrated that there was eight days where the resident had not engaged in a meaningful community activity. To ensure the gaps were not a result of non-recording, the tracker was compared against the resident's daily reports.

In January after staff reviewed the resident's daily tracker and daily written reports, it was found that there was twelve days were the resident was not provided the opportunity to engage in their community, two of the days were noted as bad weather however, there was no explanation for the other days. On review of some of the on-site activities, a similar activity of hand and foot massage was recording. Overall, during the month of January, there was very little individualised meaningful activities provided to the resident.

Current staff vacancies and staff arrangements were also impacting on providing an adequate on-site day service to the resident and in particular, where the second staff member (relief or agency) could not administer medication (notably, rescue medication).

Overall, this meant that, on a regular basis, the resident was not provided with opportunities to take part in activities which matched their interests, capacities and developmental needs. It also meant that they were provided minimum opportunities to take part in activities that promoted their physical and mental health, enhance their wellbeing and encourage socialisation.

Judgment: Substantially compliant

Regulation 17: Premises

On a walk around of the designated centre, the inspector observed a number of maintenance upkeep and repair works that were required. A number of these were impacting on the effectiveness of the infection prevention and control measures in place. The inspector observed that the state of disrepair of some areas of the house, such as worn and stained carpet and warped timber floor suggested they had been in disrepair for a lengthy time.

The inspector was informed that a maintenance list had been submitted to the maintenance department in 2024 however, the maintenance department had advised the new person in charge that they had not received a list during 2024.

The person in charge submitted a list of required upkeep and repair works to the maintenance department in February 2025 (many which are listed under Regulation 27) however, as of the day of the inspection, there was no plan or timeline in place to complete the works.

There was a room upstairs, which the inspector was informed was now used as a staff office (previously a staff sleepover room). The room was observed to contain a lot of items that were not appropriately stored. The room overall was observed as cluttered and untidy and did not provide a suitable environment for a staff office. The room contained a bed, residents' archive folders, large boxes of old documents related to residents and administration of the designated centre and staff storage cubes. In addition, the inspector observed old opened and sealed paint cans, used paint trays and paintbrushes, silicon tubes, activity games and plastic boxes spread around the floor of the room.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents which met the requirements of regulation 20. For example, on review of the guide, the inspector saw that information in the residents' guide aligned with the requirements of

associated regulations, specifically the statement of purpose, residents' rights, communication, visits, admissions and contract for the provision of services, and the complaints procedure.

The guide was written in easy to read language and was available to everyone in the designated centre.

Judgment: Compliant

Regulation 26: Risk management procedures

Since commencing their role in the centre the person in charge had reviewed and updated the centre's risk register in February 2025. However, it was unclear on the register when it had last been reviewed. There were anomalies on the new risk register's dates of issue and review and it could not be determined when it was last reviewed. for example, the current risk register noted the following information: Date of issue 01/03/2020, created 01/03/2020, Review date February 2026.

On review of a sample of associated risk assessments, the inspector saw that they had last been reviewed in 2022. For example;

An assessment relating to the risk of residents' non-compliance with evacuation in the case of fire, noted that it was created in March 2022 and due for review in April 2023.

Risk assessments regarding COVID-19, infection prevention and control, residents self-injurious behaviours and staff working along were last reviewed in October 2022.

An assessment relating to fire safety risks was last reviewed in March 2023.

In addition, on the day of the inspection a number of risks had been identified by the inspector which potentially impacted on the safety of residents. For example;

Risk associated with the non-completion of a fire drill with the least amount of staff and maximum amount of residents.

Risks associated with obstruction issues identified on a fire drill in May 2024.

Risks associated with lone working agency or relief staff who have not completed a night-time fire drill.

Risks associated with inconsistent and lack of adequate leadership, staff supervision and oversight in the centre.

Risks associated with high turnover of persons in charge during a short period of time.

This meant that the provider had not ensured that the system in place for the assessment, manage and ongoing review of risk was adequate or effective. There had been no adequate review of the measures in place, that mitigate and reduce risks, which meant that overall, there was a potential health and safety risk to residents living in the centre until the risks were appropriately addressed or reviewed.

Judgment: Not compliant

Regulation 27: Protection against infection

Due to the poor upkeep and repair of areas of the premises of the designated centre, the register provider was not ensuring that residents who may be at risk of a healthcare associate infection were protected.

One of the residents living in the centre liked to mobilise around the premises on the floor in a seated position. Where areas of the floor were in disrepair and could not be cleaned effectively, this meant that there was a risk of the resident contaminating healthcare associated infectious deceases.

In addition to the warped hallway flooring there were other areas of poor upkeep and maintenance that posed a risk to the infection prevention and control measures in place, which overall posed potential a safety risk to residents living in the house. The following issues required attention;

Rust on the toilet handrails in the downstairs bathroom

Peeling and chipped paint on doors and door frames in the house

Stairs carpet was observed to be unclean with ingrained marks and stairs

Kitchen cabinets around the cooker hob and fan were warped and chipped.

The kitchen counter top was badly worn.

On one of the resident's bedroom walls was observed to have peeling paint and was grubby in areas.

The sealant on the base of the shower in the upstairs en-suite was chipped.

Floor covering was missing in two areas of the downstairs office which was impacting on the effectiveness of the cleaning of the floor. The inspector was also

informed that the resident, who like to mobilise on the floor, regularly enjoyed coming in to the office and sitting on the floor.

There was a number of unused old soap dispensers attached to the walls in bathrooms and the laundry room area. The inspector observed them to be unclean with residue from sticky tape on one of them where dirt had built up on it.

Two of the cupboards in the laundry room were observed as unclean.

Green and blue mop heads and all buckets were stored outside in an outdoor storage box with no lid. Two red mop heads were observed to be stored in an unclean cupboard under the sink in laundry room. Overall a review of the storage of the centre's mops and buckets was required.

The sink and draining board in the laundry area required cleaning. There was paint residue observed in both areas.

The timber radiator cover in downstairs hallway was observed to be scuffed with chipped paint.

As mentioned in regulation 17, there was no plan or timeline to complete the above issues. As such the provider was not ensuring that residents were living in a safe and hygienic environment at all times.

Judgment: Not compliant

Regulation 28: Fire precautions

On review of fire drill records, the inspector saw that there had been no fire drill completed in the designated centre with the lowest amount of staff and the highest amount of residents. Three residents required assistance if required to evacuate during the night, for example, one resident's assessed needs required a bed evacuation through their bedroom double doors, one resident required wheelchair assistance and another resident who was diagnosed with early stages of dementia also required assistance. This meant that, during times that there were five residents sleeping in the house with one waking night staff, the provider could not be assured that residents could be safely evacuated from the designated centre in the case of a fire.

The inspector was informed from management and staff that lone working relief or agency staff, employed to complete a waking night shift, had not taken part in a night time fire drill. The roster demonstrated that for the majority of January and February and in to March 2025, the same agency staff worked night shifts however, they had not taken part in a fire drill (to evacuation residents) in the centre.

The Fire evacuation plan observed hanging on the wall next to the front door contained minimum information and did not correspond with the fire evacuation

plan in the fire safety folder. The fire evacuation plan in the fire safety folder had not reviewed since 2023. Since that time there had been changes to some of the assessed needs of residents as well as issued identified on fire drills.

A day time fire drill that took place in 2024 noted an issue regarding egress from the back fire exit that slowed the evacuation down. The record of the fire drill noted that a resident's mobility aid had to be turned the opposite way to fit out the door. The issue had not been progressed to senior service manager or fire safety department. The evacuation plan had not been updated nor had the resident's personal evacuation plan to reflect this issue. None of the provider related audits had identified this issue.

A night time fire drill record that took place in 2024 inaccurately recorded two staff and four residents had completed the drill. On speaking with staff, the inspector was informed that one staff completed the drill and a new staff member watched on as part of their induction. The inspector was informed that there was an obstruction in the room when the resident's bed was been pushed out through the double doors. While this had been removed by the second staff during the drill, the issue had not been raised or progressed in line with the provider's policy.

The inspector observed a door stopper at the back door which was a fire exit. The inspector was informed that the back door was often wedged open as the room gets very hot due to the two laundry machines next to it. On the day of the inspection, the person in charge removed the stopper.

The fire door in the sitting room was observed as not staying fully open (an electronic arm linked to the fire alarm was in operation). The door frame was observed to be in disrepair beside the hinge of the electronic closer. This issue had not been identified during any fire safety checks or provider led audits. On the day of the inspection, the person in charge contacted the maintenance department about the issue.

Local fire safety quarterly audits, that had been completed during July 2024 to January 2025, were found not effective as they had not identified any of the above issues.

Service records completed by an external fire safety company showed that the fire extinguishers in the house had been last serviced by an external company on 31/01/2025. The inspector observed the recording on the certificate to be inadequate. For example, there was no signature or appropriately written comment from the person completing the service in 2024 and 2025.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents were provided with annual reviews of their personal plans including reviewing goals achieved and planning for new goals. On review of four residents' annual personal planning meetings, the inspector saw that the meetings were person-centred, meaningful and delivered in a way that was in line with each resident's understanding and preference of communication.

The inspector observed photographs of meetings where large whiteboards where used with pictures of residents' achievements and newly planned goals, residents family and people who were important to them were invited to the meeting and supported residents with their achievement and goals.

However, the inspector found that some improvements were needed to enhance this area of residents' personal plans. The inspector found that not all goals were meaningful in nature, individualised or relevant to each resident. Daily activities such as gardening, community activities, group outings or day service events were put forward as goals. Other goals were not within reach of residents remit, for example one goal for one resident included an overnight break in a hotel in Ireland. However, it was noted that the goal could not be achieved as the resident struggled with money management which was impacting on saving as part of the goal

Where progress of goals were recorded, they did not provide sufficient information to demonstrate how each resident had been supported to progress the goal or how it had improved their lives. Overall, a review of each resident's goal planning was needed to ensure that residents were supported to engage in their home and community in a meaningful way and be supported to progress and develop in a way where they could celebrate achievements.

Judgment: Substantially compliant

Regulation 8: Protection

There were a number of risk assessments and support plans in place to ensure residents safety, in regards to keeping safe at home and in the community. On a review of staff files (as per Schedule 2) the inspector saw that all staff had underwent the Garda vetting system.

Overall, staff facilitated a supportive environment which enabled the residents to feel safe and protected from abuse. The inspector found that staff treated residents with respect and that staff providing personal intimate care to residents, who required such assistance, did so in line with each resident's personal plan and in a manner that respected residents' dignity and bodily integrity.

However, some improvements were needed to ensure that all staff were fully aware and familiar with reporting systems in place, should a safeguarding concern arise. For example, where there had been an alleged safeguarding concern in March 2025, relating to a resident's finance, this had not been raised with the person in charge in a timely manner or in line with the provider's policy or best practice. It also meant

that the concern was not reviewed, screened or reported in accordance with national policy or regulatory requirement. As such, this meant that no appropriate measures had been put in place during this time to mitigate the risk of a similar incidents recurring.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for 49 Rathbeale Road OSV-0002393

Inspection ID: MON-0037558

Date of inspection: 26/03/2025

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • New PIC has been recruited, currently going through onboarding, and estimated to start by 30.06.2025. • This PIC will be full time and solely based in the centre. • Current PIC will provide a one-month handover period for the new PIC • Change of PIC notifications will be submitted as required.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Roster review was held 11th April to vacancies levels confirmed. • New Full time PIC due to start by 30.06.2025. • New full SCW starting June 2025 • Regular relief panel (with familiar staff) now in place from April 2025. • Risk assessment now in place for the use of block booking familiar agency staff to ensure constituency of care for the residents. • Two current staff members have increased their hours reducing the vacancies by 0.5 wte and ensuring more consistency.	

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• HSE Dementia Training scheduled for the team in June 2025.
• Staff team scheduled to attend New Directions Training 26.08.2025.
• The team have been put forward for QQI training and are awaiting dates.
• Supervision in place. Full staff team have received supervision accept one staff who has been out sick in April – this has been rescheduled for May.
• All supervisions have been documented and are stored in the centre.
• Inconsistent archiving accounting for deficits in supervision paperwork- New Archiving system to be implemented to ensure supervision records are stored and archived correctly.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Full time PIC will be in place by 30.06.2025. This pic will be full time and solely based in the centre.
• New full time SCW starting June 2025
• Regular relief panel now in place from April 2025.
• Current PIC will provide a one-month handover period for the new PIC.
• NIMs & Quality & Safety Administrator is attending staff meeting 21.05.2025 to provide training on accidents/incidents (Eforms), how to complete and the importance.
• Going forward six monthly will be completed every six months.
• H&S checklist to be completed in line with SMH policy.
• LFO to compete specific LFO training on the OTC by 01.07.2025 – this training highlights fire escalation pathways to SMH Fire Officer. There is a PIC in place to support with escalation.
• Now all staff have received supervision except for one staff who is out sick- rescheduled for May 2025.
• Roster review was completed 11th April and level of vacancies confirmed.
• PIC reviewed All risk assessments and risk register to ensure all risk are captured with new risks assessments now implemented.
• Risk assessments to be reviewed quarterly or when required as per Policy.
• Change of PIC notifications will be submitted as required
• 2024 HIQA notifications submitted retrospectively on 30.04.2025.
• The Quality and Risk Manager to review risk management systems in the centre by 31.05.2025.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Safeguarding audit was completed 28.04.2025 with recommended actions for the PIC and team.
• The Designated Officer to provide training to staff team 21.05.2025 on the Safeguarding Policy, the pathway, how to complete PSF1 and HIQA Notifications pathway
• Incident on 9th was screened, NF06 was completed, PSF1 completed. 2 safeguarding meetings completed and new financial local policy now in place- No grounds for concern identified.
• PIC submitted 2024 retrospective HIQA notifications 30.04.2025.
• All incidents will be notified to HIQA in line with the regulations.

Regulation 32: Notification of periods when the person in charge is absent	Not Compliant

Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent:
• NF30s will be submitted in line with regulation going forward.
• Areas of responsibility/accountability to be delegated to each staff- supervision will be in place to support staff in their role.
• One staff to be identified and trained to support PIC on the portal with notifications by 30.06.2025

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Not Compliant

Outline how you are going to come into compliance with Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent:
• NF30s will be submitted in line with regulation going forward and will confirm arrangements to cover the PICs absence.
• Areas of responsibility/accountability to be delegated to each staff- supervision and any

necessary training will be in place to support staff in their role.
• One staff to be identified and trained to support PIC on the portal with notifications by 30.06.2025.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• The Local Day Centre Co-Ordinator carried out a review on the current day service provided with relevant actions. A new directions folder now in place containing New Directions Easi-tool.

• Staff team scheduled to attend New Directions Training 26.08.2025.

• The team have been put forward for QQI training and are awaiting dates.

• Day Service Profile to be completed by 05.06.2025 for one resident for day service wait list

• Day service materials and storage area now allocated in resident bedroom for day service materials.

• New day service timetable template now in place with a variety of activities

• Pic to discuss day service tracker sheet and the requirement to compete is a mandatory duty at next staff meeting 21.05.2025. PIC is monitoring use of tracker and it is currently in use by all staff members.

• Following a roster review, arrangements have been made that there will always be two staff on during the resident's day service hours and one of these staff will be Midaz trained so the residents day service hours are protected. The 08:00-21:00 has been assigned on the roster to facilitate the resident's day service hours.

• PCP Co-Ordinator will attend June staff meeting and discuss the PCP process such as AON, Support Plans and Goal identification and tracking.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: • A full project of works has been approved to address the identified issues with the premises and IPC. • These works will be completed by October 2025. • Risk assessment now in place for ongoing premises and IPC issues and will remain in place until works completed in October 2025.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • New PIC will commence on June 2025 and the current PIC will provide a one-month handover period for the new PIC. • The new PIC will ensure risk assessments and register be reviewed quarterly and have oversight of risk management. • Current PIC from February 2025 had completed risk assessment and register review in February 2025 and April 2025 and has strong governance over risk management. • Current PIC will review risk register in June 2025. • Risk of residents' non-compliance with evacuation in the case of fire was reviewed by PIC and Fire Officer 08.04.2025 and new evacuation plan now in place for this resident. • Risk assessments regarding COVID-19, infection prevention and control, residents' self-injurious behaviors and staff working alone were reviewed by current PIC February 2025 and will be reviewed again in May 2025 (or when required) . • A simulated fire drill with the least amount of staff and maximum amount of residents was completed 28.03.2025. • Risks associated with obstruction issues were reviewed by PIC and Fore Officer and rectified- fire door has been fixed and fire exit in one resident's room now has a ramp for ease of access. • Risks associated with lone working agency or relief staff who have not completed a night-time fire drill- The PIC in charge will endeavor to ensure regular relief and agency complete a simulated fire drill. A new handover template has been implemented for relief and agency staff, which highlights the fire evacuation for the centre and other associated risk. • Risks associated with inconsistent and lack of adequate leadership, staff supervision and oversight in the centre- current PIC in place since February 2025 and new PIC will commence in June 2025. • Two new risk assessments (for residents and staff) in place for risks associated with high turnover of persons in charge during a short period of time. There is a PIC in place since February 2025 ad a new full time PIC will commence in June 2025. • All risks were reviewed by current PIC in April 2025, and any identified risk now have a relevant risk assessment attached and will be reviewed again in June 2025.	

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• A full project of works has been approved to address the identified issues with the premises and IPC.
• These works will be completed by October 2025.
• Risk assessment now in place for ongoing premises and IPC issues.
• Referral sent to OT by PIC regarding replacement handrails in the downstairs bathroom- new handrails will be ordered and fitted by TSD before 30.06.2025.
• Peeling and chipped paint on doors and door frames in the house- will be completed in works project
• Stair's carpet will be replaced in works project
• Issues with Kitchen cabinets and counter will be rectified in works project
• one of the resident's bedrooms to be repainted and completed in works project.
• Staff office flooring will be rectified in works project
• Request to removed old unused old soap dispensers and reseal shower sent to maintenance 30.04.2025.
• Cupboards in the laundry room have been deep cleaned.
• Buckets now stored in shed and new buckets purchased.
• New mop heads and storage box purchased.
• The laundry sink and draining area has been deep cleaned.
• The timber radiator cover will be repainted in works project

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The provider had failed to ensure that there were effective fire safety management systems in place in the designated centre.

• The centre has a fire management system in place as per the St. Michaels House fire risk mgmt. policy and strategy. It is acknowledged some gaps were identified on the day which will be reviewed and addressed. The SMH Fire Officer will support the new PIC to address issues noted. All evacuation plans where reviewed, with one residents point of evacuation changing from bench to the bus. Fire drill with five residents and one staff was completed 28.03.2025. following the fire drill, the unit evacuation plans were reviewed and updated. LFO to complete specific SMH LFO training.

On review of fire drill records, the inspector saw that there had been no fire drill completed in the designated centre with the lowest amount of staff and the highest amount of residents. Three residents required assistance to evacuation during the night, for example, one resident's needs required a bed evacuation through double doors, one resident required wheelchair assistance and another who was diagnosed with early stages of dementia also required assistance. This meant that, during times that there were five residents sleeping in the house with one waking night staff, the provider could not be assured that resident could be safely evacuated from the designated centre in the case of a fire.

• Fire drill with five residents and 1 staff will be completed 28.03.2025. PIC sent fire drill report to inspector as requested. On the 09.12.24 fire training was completed with the team. As part of this a simulated role play training was completed in rotation with each staff member in attendance. This was a fire evacuation replicating night-time conditions and 1 staff completed same in rotation. It took on average 2m53s for the team. The staff members role played the service users. This included moving a resident's bed which each staff practised. Any staff that missed this training will complete the alarmed fire drills to counterbalance missing the exercise.
• This exercise included all elements of the evacuation plan such as reading the fire alarm panel, contacting the fire brigade and evacuating the house. Any issues raised were discussed at the training.
• Going forward, training drills with the fire officer will be logged on an EForm.

The inspector was informed from management and staff that lone working relief or agency staff, employed to complete a waking night shift, had not taken part in a night time fire drill. The roster demonstrated that for the majority of January and February and in to March 2025 the same agency staff worked night shifts however, they had not taken part in a fire drill (to evacuation residents) in the centre.
• Following consultation and advise with SMH fire officer in order to prevent desensitisation of service users it is not practicable to complete an alarmed fire drill for each unfamiliar staff that is to cover a shift. This could lead to complacency and non-evacuation over time. The unfamiliar staff is walked and talked through the evacuation on handover.
• The PIC in charge will endeavour to ensure regular relief and agency complete a simulated fire drill. A new handover template has been implemented for relief and agency staff, which highlights the fire evacuation for the centre and other associated risk.
• Fire safety and evacuation is discussed weekly with residents at residents' meetings. The Fire evacuation plan observed hanging on the wall next to the front door contained minimum information and did not correspond with the fire evacuation plan in the fire safety folder. The fire evacuation plan in the fire safety folder had not reviewed since 2023. Since that time there had been changes to some of the assessed needs of residents.

• This fire evacuation plan has been removed from the wall. The fire evacuation plan for the centre will be reviewed and updated 31.03.2025 in consultation with the fire officer, its advised that St Michaels House does not post the full fire evacuation plan on the wall in the centre. This is not practicable nor in keeping with a homely environment.

• The evacuation plan is in the emergency file which any unfamiliar staff is provided with for reference if needed.

• Staff refresh on the evacuation plan annually at fire training through the simulated role play training. Handover provides the necessary information for an unfamiliar staff to complete the evacuation.

A daytime fire drill that took place in 2024 noted an issue regarding egress from the back fire exit that slowed the evacuation down. The record of the fire drill noted that a resident's mobility aid had to be turned the opposite way to fit out the door. The issued had not been progressed to senior service manager or fire safety department. The evacuation plan had not been updated nor had the president's personal evacuation plan to reflect this issue.

• The issue has been escalated to the fire officer and Technical Service Department (TSD). The works were completed in April 2025.

• The fire door issue was rectified on 04.04.2025 with one residents fire evacuation plan updated to reflect this.

A night-time fire drill record that took place in 2024 inaccurately recorded two staff and four residents had completed the drill. On speaking with staff, the inspector was informed that one staff completed the drill and a new staff member watched on as part of their induction. The drill record noted that there was an obstruction in the room when the resident's bed was been pushed out through the double doors. While this had been removed by the second staff during the drill, the issue had not been raised or progressed in line with the provider's policy.

• Ramp was fitted on 4th April 2025 to allow ease of access for evacuation.

The inspector observed a door stopper at the back door which was a fire exit. The inspector was informed that the back door is often wedged open as the room gets very hot due to the two laundry machines next to it.

• Escalated to TSD who will review. The door stopper was removed from the centre on day of inspection.

The fire door in the sitting room was observed as not staying open fully. An area of the door frame was in disrepair. There was an open chunk on the doorframe next to where the hinge of the electronic closer was screwed in to. This issue had not been identified during any fire safety checks or provider led audits. On the day of the inspection, the person in charge contacted the maintenance department about it.

• The fire door issue was rectified on 04.04.2025 with one residents fire evacuation plan updated to reflect this.

Local fire safety quarterly audits that had been completed during July 2024 to January 2025 were not effective. They had not identified any of the above issues.

• The LFO will complete SMH LFO training. There will be greater oversight from the new PIC and increased visits from the service manager to the centre.

Service records completed by an external fire safety company showed that the fire extinguishers in the house had been last serviced by an external company on 31/01/2025. The inspector observed the recording on the certificate to be inadequate. For example, there was no signature or appropriately written comment from the person completing the service in 2024 and 2025.

• The signed job sheet from MCL as is now available in the emergency folder in the centre. The fire officer will revise an alternative process instead of local sign off with contractor.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• PCP Co-Ordinator to attend staff meeting in June 2025 to discuss personal plans and how to document and the refresh the PCP process.
• Keyworking roles have been reviewed and there has been a change in keyworking roles to reflect the needs to the resident with the contracted hours of staff.
• Keyworkers have reviewed goals and new goals identified in line with the will and preference of each resident.
• New goal tacker in place will allow for more comprehensive tracking of goals.
• A goal for 2025 is for all staff to compete the e-learning rights training/right based practice modules on HSELand and HIQA.
• PCPs is now a standing agenda item at all staff meetings.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Safeguarding audit completed on 28.04.2025 with action plan in place.
• Safeguarding is now a standing agenda item at all staff meetings.
• The Designated Officer to provide training to staff team on 21.05.2025 on the Safeguarding Policy, the pathway, how to complete PSF1 and HIQA Notifications pathway.
• Incident on 9th was screened, NF06 was completed, PSF1 completed. 2 safeguarding meetings completed and new financial local policy now in place- No grounds for concern

identified.
• PIC submitted 2024 retrospective HIQA notifications 30.04.2025.
• All staff have complete safeguarding and children's first.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	31/05/2025
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/05/2025
Regulation 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Substantially Compliant	Yellow	30/06/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is	Not Compliant	Orange	30/06/2025

	appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	01/05/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/05/2025
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/10/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/06/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the	Not Compliant	Orange	01/05/2025

	designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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	01/05/2025
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	02/05/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and	Substantially Compliant	Yellow	01/05/2025

	shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	01/05/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/05/2025
Regulation 27	The registered provider shall ensure that residents who may be at risk of a	Not Compliant	Orange	31/10/2025

	healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	04/04/2025
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	01/04/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	04/04/2025
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably	Not Compliant	Orange	01/04/2025

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	01/04/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	01/05/2025
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive	Not Compliant	Orange	01/05/2025

	procedure including physical, chemical or environmental restraint was used.			
Regulation 32(1)	Where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more, the registered provider shall give notice in writing to the chief inspector of the proposed absence.	Not Compliant	Orange	01/05/2025
Regulation 33(2)(a)	The notice referred to in paragraph (1) shall specify the arrangements which have been or were made for the running of the designated centre during the absence of the person in charge.	Not Compliant	Orange	01/05/2025
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.	Substantially Compliant	Yellow	01/05/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	01/05/2025