



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Ballybrack
Name of provider:	St John of God Community Services CLG
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	17 June 2026
Centre ID:	OSV-0002884
Fieldwork ID:	MON-0050711

About the designated centre

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

Ballybrack designated centre operated by St John of God Community Services Company Limited by Guarantee consisting of three residential community premises both located in South County Dublin. The designated centre intends to meet the specific care and support needs of adults with an intellectual disability. Residents in Ballybrack designated centre require low to medium assistance with their care and support needs. Residents health needs are monitored by a GP of their choice and they are supported by staff to attend medical check-ups as required. One residential house can accommodate up to six residents, the other residential house can accommodate up to four residents and the apartment, one resident. One of the houses caters for males only, the other residence caters for both male and female residents. Residents are supported to travel independently and have access to transport provided by St John of God Services, either through sharing with other locations or with a vehicle assigned to the location. The centre is managed by a person in charge who is supported in their role by a social care leader. The person in is also responsible for one other designated centre. The staff team is made up of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8
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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 17 June 2026	09:20hrs to 17:30hrs	Jacqueline Joynt	Lead
Thursday 18 June 2026	13:15hrs to 17:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over the course of two days to monitor the designated centre's level of compliance with the regulations and in particular, to ensure residents living in the centre were provided with the services in accordance to the centre's statement of purpose.

Overall, the inspector found that while the person in charge and staff team were striving to provide good care and support to residents, a number of deficits were identified on the inspection. The provider had carried out a review of the quality of care and support in the centre in April 2026 and had found high levels of non-compliance with the regulations. An action plan which included the persons responsible as well as appropriate times lines was put in place to address the issues presenting. There was evidence of good traction of the action plan however, on the day of the inspection, further deficits were found in the areas of governance and management, protection, medication management, notification of incidents, fire safety and residents' rights. The inspector found that the provider had failed to ensure that the oversight and monitoring systems in place were effective in ensuring a safe and good quality service was provided to residents living in the centre.

For example, the inspector observed poor medication practices, lack of identification and follow up on safeguarding incidents, poor oversight of notifying incidents, unsafe fire precaution practices, inadequate and untimely response to residents' complaints. These issues meant that residents' rights to a safe and quality services was not promoted and overall was having a negative impact on their lived experience in the designated centre. Each of the deficits are discussed in detail in the next two sections of the report.

The inspector used observations, conversations with the person in charge, the social care leader, the person participating in management and staff members and engagements and conversations with residents, as well as a review of documentation to form judgments on compliance with the regulations inspected.

On arrival at the centre the inspector provided the person in charge and the social care leader with a 'nice to meet you' document to share with the residents in each of the designated centre's locations. The document included easy-to-read information about the inspector, why they were visiting the residents' home and overall, what the inspection entailed. This document was in place to support residents understand the inspection process, but also to support residents in relation to unexpected visitors in their home.

The centre was made up of three units; Two houses and one apartment. Each unit was approximately five to ten minutes' drive away from each other. The designated centre was currently registered for eleven residents. One of the houses, that included a single occupancy apartment, provided accommodation for six residents,

the other house provided accommodation for four residents. The third unit was a stand-alone single occupancy apartment and was home to one resident. In 2025, the resident had been supported to move from the four bedroom house to the apartment as it better met their needs. Staff who spoke with the inspector advised that the resident was happy living in the apartment and that there had been a significant reduction in behavioural incidents since they moved there. In addition, there had been significant reduction in safeguarding concerns in the house that they moved from. Overall, the move had resulted in positive outcomes for all residents concerned.

In the house that accommodated six residents there were currently five residents living in it. A potential sixth resident was going through the familiarisation phase of the admission process to see if the house met their needs. They had visited the house on a number of occasions and met with residents. There was a record of each visit to support the next step which included a transition plan, should the resident choose to move into the house. This was also to ensure the safety of the resident as well as the other residents living in the house. The visits had recently moved to a slower pace as not all visits were currently resulting in positive outcomes for the resident.

Over the past number of months, one of the residents living in this house had undergone several hospital admissions due to serious health concerns, some of which had required the emergency services to come to their home. On discharge from the hospital the resident required additional healthcare supports as well as support with their new medical equipment. On the morning of the inspection, the inspector met with the resident. They had made a good recovery and were starting to return to their day service at a pace that was in line with their preference. The resident required the support of a medical machine during the night and in the morning before they went to their day service. Staff informed the inspector that the resident needed a lot of support with the equipment; they said the resident found using the machine difficult however, were making good progress.

The inspector visited the other house in the afternoon and returned to this house again on the evening to meet with the other residents. On meeting and chatting with the residents, the inspector found that residents in this house were supported to engage in their community in a way that was meaningful to them and supported their interests. All resident living in the centre were supported to attend a day service.

Residents were supported to acknowledge and celebrated occasions that were of importance to them. Some of the residents chatted to the inspector about a recent birthday celebration for one of the residents. One resident expressed their happiness about the cake and presents and fun time they had. Another resident told the inspector that it was their birthday the following month and they were looking forward to their party. Residents talked about their weekly household meetings. The told the inspector that this was where they made choices about their weekly dinner menu as well as community activities for the week.

One of the residents asked to meet with the inspector in their bedroom as they did not want to join the rest of the residents in the kitchen. Staff informed the inspector that the resident tended to prefer being on their own in their home. On speaking with the resident, they expressed their happiness about the layout and décor of their room and told the inspector that they had been consulted about the décor in their room. They were particularly excited about their television and were looking forward to watching their favourite soaps that evening. The resident said that they liked the staff supporting them and that they were looking forward to going on their scooter later that evening with one of their staff members.

A staff member showed the inspector a number of social stories that had been developed to support the resident in building positive engagement with their peers. There was also a social story to support the resident to participate in fire drill evacuations as recently they had started to refuse to leave their home during fire drills. Overall, the inspector found that the person in charge and staff had ensured that the resident was supported to understand matters, that were important to their safety and wellbeing, through a form of communication that was in line with the resident's assessed needs and preference.

The resident living in the apartment (that was attached to the house) was asked if they would like to come into the house to meet with the inspector and join the conversation. However, the resident declined and their wish was respected. Early in the day the inspector had viewed the resident's apartment and saw that it was decorated and laid out in line with the resident's likes and preferences. The inspector observed some kitchen cupboards that required cleaning as well as some areas of the house that required upkeep and repair. The latter had been identified by the provider and there were plans in place to convert the resident's bathroom facility into a shower facility, which overall would better meet their changing physical needs.

On speaking with staff in the house, the inspector found that they were knowledgeable and aware of each of the resident's support needs. They were mindful of the different personalities and unique traits of each resident. Engagement between the staff and residents was observed as kind and caring. Overall, the inspector found that staff were invested in supporting and caring for residents to the best of their ability and overall, were endeavouring to ensure that records relating to the care and support provided to residents were reflective of practice.

Staff told the inspector that it was a very busy house and at times was difficult to get time to complete the administration part of their role. Staff informed the inspector that they had recently been provided additional hours to allow them to review and update records relating to the care and support of residents. However, due to the increased healthcare support needs of one resident, additional hours were often used to support this resident during their stay in hospital. In addition, staff relayed that one resident liked to spend time on their own away from the other residents. This required more support from staff as sometimes the resident's interactions with their peers led to behavioural incidents. Staff also informed the

inspector that there had been a lot of change in management over the last six months.

On visiting the second house, which provided accommodation for four residents, the inspector met with the two residents living in the house. Currently, there were two vacancies in the house however, a potential resident was visiting the house on a regular basis. In addition, one of the residents currently living in the house was being supported to transition to another designated centre that would better meet their healthcare needs. The inspector was informed that the designated centre they were moving to provided a service for residents with a dementia diagnosis. To date the resident had made numerous visits to the centre and met with the staff and residents living there. This was part of the transition plan to ensure a smooth and safe move for the resident. Currently the resident was supported by one to one staff during the day and a dementia specific nurse at night time. The resident sat with the inspector at the dining table for a short period and appeared comfortable and content in their environment during this time.

The other resident living in the house was happy to show the inspector their bedroom. They told the inspector that they liked their room and liked living in the house. The resident appeared relaxed and content in their room and had plans to go to the local men's shed group that afternoon.

The inspector saw that staff moved at the pace that each resident preferred and offered choice and options to each resident through out the afternoon. For example, the inspector observed one staff member support a resident with their mobility equipment and in a way that promoted the resident's independence. In addition, where one resident requested to go the men shed group with the social care leader rather than their staff member, the resident's choice was respected. Later that afternoon, arrangements were made for the social care leader to accompany the resident.

On the second day of the inspection, the inspector met with the resident living in the third unit of the designated centre, a single occupancy apartment with a small apartment block. The resident shook the inspector's hand and welcomed them to their home. The inspector observed the staff member support the resident to ease into returning home from their day service at a pace that met the resident's needs and preferences. They supported the resident to have a drink and snack and take some time out before having a chat with the inspector. The inspector observed that the staff member was very knowledgeable of the resident's assessed needs and in particular, their behavioural needs, their communication needs as well as their specific likes and preferences. It was clear that the staff member understood what the resident was verbalising to them and the resident understood what their staff was communicating to them.

When the resident was ready and felt relaxed, they spoke with the inspector. They told the inspector about one of their current goals. The resident talked about an upcoming concert they were looking forward to attending with their staff member. They had a plan that week to buy a t-shirt with the band's name on it so they could

wear to the concert. The resident expressed their happiness and excitement about the activity and talked a lot about their plans for the concert.

The resident was happy to show the inspector around their apartment. They seemed particularly proud of their bedroom. They had lots of music memorabilia, compact discs and posters in their room. The resident said that they enjoyed living in the apartment by themselves. They told the inspector that they also enjoyed when family and friends visited their home. On review of the resident's personal plan, the inspector saw a number of photographs of the resident with their family and friends visiting their home and enjoying various activities both in their home and in the community.

The inspector carried out an observational walk around all units within the designated centre over the two days of the inspection. There had been a lot of structural improvements to one of the houses since the last inspection. This had resulted in positive outcomes for the residents and overall reduced the previous infection prevention control risks that had been presenting in the house. A new kitchen had been installed as well as new flooring on the ground and upstairs floors in the house. The house presented as clean and tidy and the environment provided a warm and welcoming feel to it. All residents were provided with their own bedrooms which were laid out in a way that was of preference to them. One resident lived in a single occupancy apartment that was attached to the house. Some upkeep and repair work was needed to areas of the house and apartment, most of which had been identified by the provider with a maintenance plan and time-frame in place.

The second house was also observed to be clean and tidy and in good structural upkeep and repair. Residents were consulted about the décor and layout of their rooms which contained framed family photographs, soft furnishings and memorabilia that was of importance to each resident. One resident had a keen interest in office work and this was reflected in their room through some of the furniture provided, such as a desk and chair, a small filing cabinet and stationary shelving.

Communal spaces in both houses were clean and tidy and were spacious in size and layout. In one house, the sitting room had been newly laid out with a large television, ample comfortable seating and soft furnishings. The room was observed to be bright and airy and provided a relaxing space for resident to enjoy.

Overall, the shower and toilet facilities in the houses were maintained to a good standard. Some of the facilities had been provided an upgrade with new shower, tiling and flooring. However, there were some small areas of the two houses that required upkeep and repair to ensure they could be cleaned effectively, in terms of infection prevention and control. This is addressed fully under Regulation 27.

The single occupancy apartment was observed as clean and tidy and was laid out in a way that met the resident's needs. The resident had been consulted in the layout and décor of their apartment before they moved into it. The inspector observed an area of the hall flooring to be raised due to flooding damage. The provider had been

made aware of the issue with the flooring and the landlord had been contacted however, on the day there was not timeline in place for the work to be completed.

The resident, through the support of their staff, had logged complaints about the damage to the floor and timeliness of the maintenance. They had also made complaints about two other matters relating to a neighbour's dog and the service's vehicle. Overall, the inspector found that there was little evidence to demonstrate that the resident had been provided with an adequate response to complaints made. This is addressed further under regulation 9.

The inspector found that all residents were encouraged and supported around active decision making and social inclusion. Residents participated in weekly residents' meetings where household tasks, community activities, and menu choices were discussed. There were meal planner posters in the kitchen of two houses with meals that had been chosen by the residents. The inspector also observed photograph-style staff rosters in place, which supported residents know the days staff were working on. Staff told the inspector that the roster was very important for residents as they were always keen to know who was working on each day.

In summary, the inspector found that the provider, person in charge and staff were striving to ensure each resident's wellbeing and welfare was maintained to a good standard. However, a number of improvements were needed to the current oversight and monitoring systems in place the centre. Due to the number of deficits found on the inspection, the provider could not be assured that the current systems in place were adequate in ensuring residents' safety at all times. Overall, this was impacting on the promotion of residents' rights and resulting in negative outcomes for residents.

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 impact 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 provider had failed to implement adequate management systems that were effective in ensuring residents were safeguarded and were in receipt of a good quality and person-centred service at all times.

The current governance and management systems in were not ensuring the effective governance, operational management and administration of the designated

centre. A review of the monitoring and oversight systems in place was needed to ensure that staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre.

On completion of a six monthly visit to the designated centre in April 2026, the provider found high levels of non-compliance. The provider put an action plan in place in an attempt to bring the centre back in to compliance and ensure positive outcomes for residents. A number of the actions had been completed however, some were still in progress. Staff informed the inspector that they were provided additional hours to complete some of the deficits in residents records. However, due to changing health needs of residents it was not always possible to apply the time to the records. The provider had also provided a number of workshops to social care leaders and staff to support them with the administration and record keeping in the centre. There were plans in place for further workshops to be delivered to provide further learning and supports to staff regarding local filing systems, regulation and standards, rights awareness, audits, safeguarding, personal plans, staff rosters, quality enhancement plans and centre and staff finances.

However, despite these measures, on the day of the inspection further non-compliance with the regulations was found. These related to a number of governance and management systems, medication management, fire safety, notification of incidents, safeguarding and residents' rights. This meant that the provider's review had not been effective in identifying all deficits in the designated centre and required further review and improvement to ensure it resulted in positive outcomes for residents.

Since December 2025 there had been a number of changes to management in the designated centre, including the person participating in management, the person in charge and the social care leader. The person in charge commenced their role in the centre in February 2026. They were employed on a full-time basis and were responsible for this centre and one other. The social care leader, who supported the person in charge, commenced their role in the centre in December 2025 and worked 0.5 whole time equivalent hours (WTE) in this centre and 0.5 WTE in the other centre that the person in charge was responsible for. Overall, the inspector found that there were no adequate record to demonstrate the level of on-site presence by managers in the centre. As such the provider could not be assured that effective oversight and monitoring systems that ensure positive outcomes for residents, were sufficiently in place.

The provider had ensured that an annual review of the centre had been completed as well as unannounced six monthly visits. There was also a system in place for the person in charge and social care leader to carry out local audits in each of the units within the centre. Some of the local audits reviewed fire safety, infection prevention and control (IPC), medication management, personal plans, residents' finances, restrictive practices and health and safety.

However, on the day of the inspection, the inspector was informed that due to the quality improvement focus on the two houses, no local audits had been completed in the apartment since January 2026. This meant that local monitoring and oversight

systems to ensure the safety and quality of service provided to residents was not in place, and overall posed a potential risk to the safety of the resident living in the apartment. On the day a number of deficits relating to fire safety, complaints and residents' rights were identified.

In addition, the inspector found that not all audits in the designated centre were found to be effective. For example, in one house the local governance and management systems in place had not ensured good safeguarding practice in the centre. Not all safeguarding incidents had been identified and as a result, had not been followed up appropriately or in line with best practice. This meant that there was no safeguarding measures in place to reduce the risk of residents experiencing similar incidents.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

The staff team consisted of the person in charge, a social care leader and a team of social care workers. In one of the houses there was a dementia specific nurse employed to complete waking nights shifts. This arrangement was in place to support the assessed support needs of a resident living in the house. There was one vacancy in the centre for a 0.5 whole time equivalent social care worker. The inspector was informed that the provider was actively recruiting to fill the post.

There was a staff roster in place and for the most part it was maintained appropriately. However, the inspector found that improvements were needed to the roster so that it accurately and clearly recorded the social care leaders and person in charge's hours in this designated centre and in particular, reflected the level of on-site presence of managers in the centre. This is to ensure that there was appropriate support and supervision of staff working in the centre as well as effective governance, operational management and administration of the designated centre. (This is discussed further under Regulation 23).

A review of a sample of rosters for the months April to June 2026 indicated that there were sufficient staff on duty to meet the needs of residents on a daily basis. Gaps on the roster were completed by either part-time core members of the staff team, day service staff members or the organisation's relief staff team. There was minimum use of agency staff employed in the centre.

Where there were relief or agency staff employed, the person in charge was striving to ensure that staff, who were familiar to the residents, were employed. This was in an effort to ensure positive outcomes for residents in terms of maintaining relationships and building trusting bonds with their staff members. However, these

arrangements could not always be guaranteed and as such, posed a risk to the level of continuity of care in the centre until the full staff cohort was in place.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a system in place that supported management to evaluate staff training needs and to ensure that adequate training levels were maintained. However, improvements were needed to ensure that the system was effective at all times.

Some of the training that staff were provided related to fire safety, safeguarding, safe medicine management, food hygiene, positive behaviour supports, rights, communication, personal planning, feeding eating and drinking (FEDS) and IPC training. Staff were also provided training related to residents' assessed needs.

A recent provider six monthly review of the quality of care and support provided in the centre found that there was high levels of staff training out of date, or approaching refresher due date. On the day of the inspection, the training schedule demonstrated that since that time a lot of out of date training, as well as refresher training, had been completed by staff.

The inspector saw that more training was due to be completed within the next month or two and that a lot of training courses had been booked. For example, the inspector saw that eleven staff were due to attend fire safety training. Three staff's training was out of date with the remainder appropriating the refresher due training.

However, not all training that was out of date had a training course scheduled. For example, there was no training booked for four staff who required first aid training, one staff who required safeguarding training, one staff who required training in Triple-C communication and three staff who required training in food hygiene.

A resident was recently assessed as requiring a continuous positive airway pressure machine, (CPAP), as well as a Bi-level positive airway pressure machine (BIPAP). Staff informed the inspector that two staff members had been provided training in the hospital on how to use the machines. The staff had then showed other staff members how to use the machine. However, the inspector found that further training on how to use and clean the machines, by an appropriate trained professional, would likely enhance the training already in place.

Staff had recently been provided with a one to one supervision meeting by the social care leader. In line with the organisation's policy, two one to one supervision meetings were provided to staff per year. These meeting were in place to support staff in their role when providing care and support to residents. On speaking with the social care leader and on review of some of the supervision notes, some of the topics raised at the meetings included, annual leave, staff training, the staff roster,

key working practices, residents personal plans, risk assessment and matters relating to residents multi-disciplinary team meetings.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to ensure that the service provided to residents living in the designated was safe, consistent and effectively monitored at all times. The current oversight and monitoring systems in place in the centre were not adequate and were impacting on the effectiveness of driving quality improvement for residents living in the centre. This situation was resulting in poor outcomes for residents living in the centre and not ensuring their safety at all times.

The inspector found that there were no adequate records in place to demonstrate management on-site presence in the designated centre. The times the person in charge and the social care leader were present in the centre was not accurately reflected on the centre's roster. The person in charge informed the inspector that they visited each unit (house/apartment) in the centre at least once a week. This meant that the provider could not be assured to the level of on-site oversight across the premise in the designated centre and overall that the service provided to residents was effectively monitored.

The provider had carried out two unannounced six monthly visits of the centre which reviewed the quality of care and support provided to residents. The most recent visit in April 2026 demonstrated that there were high levels of non-compliance with the regulations. Senior management put in place an action plan to address the non-compliance. The inspector saw that while there had been a lot of traction on the action plan however, due to further high levels of non-compliance found on this inspection, a review of the effectiveness of the action plan was needed. Overall, the inspector found that the deficits in the local governance and management systems meant that the provider could not be assured of the effectiveness or consistency of systems in place to keep residents' safe at all times.

For example, this inspection found that poor and inadequate oversight systems had not ensured that all safeguarding incidents were followed up appropriately. In addition, the medication management systems in place had not ensured that all medicines in place were in date or administered as prescribed. The inspector found that there were no local audits completed in one of the units within the designated centre between January 2026 and June 2026. Furthermore, the provider had failed to ensure that restrictive practices, as well as incidents relating to safeguarding and fire alarm activation, were notified to the Chief Inspector as required by the regulations. The oversight of local fire safety systems and practices was not satisfactory and meant that there was a potential risk to the effectiveness of the fire containment facilities in one unit. Many of the deficits were resulting in negative

impacts for residents and in particular, their right to live in a service that ensured their safety at all times.

The issues mentioned above are further discussed in detail under Regulations 8, 9, 28, 29 and 31.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider and person in charge had ensured that that admissions to the centre were in line with the organisation's admissions policy and procedures as well as the information provided on the centre's statement of purpose. There was a specific committee in place for admissions who's responsibilities included meeting and identifying persons for placements based on the profile of residents already living in the centre.

There were three vacancies in the centre. In one house, where there was one vacancy, a potential resident was being supported to visit the house to see if it was in line with their needs, likes and preference. This was part of the familiarisation process. A record of each visit was recorded to assess how the potential resident, as well as the current residents were finding the experience. This was also to ensure the safety of all resident concerned. Follow the success of a familiarisation process, residents were then provided with a transition plan to support them with the next steps of their admission. This was to support a smooth and positive move for the resident into their new home.

In the other house, one resident's familiarisation process had been reviewed as meeting their needs and safe for all residents concerned and a transition plan in was in place to support their move into the centre.

Overall, residents were supported to transition into the centre at a pace the met their needs and that overall ensured their safety and the safety of residents living in the centre.

The inspector also reviewed the transition plan for the resident that moved into the apartment. The plan included easy-to-read and social stories to support the resident's understanding of the move in a communication format that met their needs. The inspector saw that the resident was provided an assessment of their needs subsequent to moving to the centre. In addition, an easy-to-read contract of care, which detailed the service to provide to the resident was in place in the resident's personal plan.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had failed to ensure that there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

For example, in relation to a notification that was required to be submitted on a quarterly basis, the inspector found that the number of restrictive practices in use in the centre during the period January to March 2026, was inaccurately notified. In addition, the notification inaccurately noted that restrictive practice reduction plans were in place. This meant that the provider was not ensuring that the restrictions in place were the least restrictive for the shortest duration and overall resulted in negative outcomes for the residents concerned.

Furthermore, adverse incidents and accidents in the designated centre, required to be notified to the Chief Inspector, had not been notified and 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). For example, four incidents relating to safeguarding and one incident relating fire alarm activation, had not been identified or notified as required.

This meant that these incidents were not provided an appropriate review. As such there was a potential risk to residents' safety as without a review, the provider could not be assured that the risk of recurrence was reduced or mitigated.

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 inspector found that the provider had failed to ensure that a safe and quality service was delivered to residents at all times.

The inspector found that improvements were needed to a number of 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 operating the service in compliance with regulations associated with medicines and pharmaceutical services, fire precautions, protection and residents' rights. Residents were not always in receipt of a safe service and this was, at times, impacting negatively on their lived experience in the their home.

From speaking with the person in charge, social care leader and with a number of staff on the day of the inspection, it was evident that they were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. Staff were endeavouring to ensure that residents' well-being and welfare were maintained by a good standard of evidence-based care and support. However, due to a number of factors this was not always possible.

There were a number of provider and local audits in place to monitor fire safety systems. However, to ensure the safety of residents, improvements were needed to ensure that fire prevention systems and oversight measures, to mitigate against the risk of fire, were effective at all times.

Improvements were needed to the practices in place for identifying and reporting safeguarding concerns. On the day of the inspection, the inspector found that not all allegations of a safeguarding concern were investigated in line with national policy and best practice.

The provider had not ensured that there were appropriate oversight systems in place to ensure medication practices in place were safe and effective at all times. This meant that some of the medication systems and practices in place, posed a potential risk to the residents' safety.

There had been significant improvements to the upkeep and repair of the centre since the last inspection which had brought improvement to the effectiveness of the infection prevention and control measures in place. However, some further improvements were observed to be required on the day that were impacting on the infection prevention control measures in place, as well as residents' rights.

Residents were provided with an assessment of need as well as support plans to meet those needs. However, some improvements were needed to ensure all residents plans were up-to-date, relevant and effectively reviewed.

While there were systems in place to promote resident's rights, the systems were not effective at all times and were resulting in negative outcomes for residents.

Overall, the inspector found that due to the high number of deficits found on this inspection, the safety and quality of care and support provided to residents could not be assured at all times and was resulting in negative outcomes for residents.

Regulation 17: Premises

The designated centre's premises consisted of three units; two houses and a single occupancy apartment. The physical environment of all units in the centre were observed to be clean and for the most part, in good decorative and structural repair however, some upkeep was required. The design and layout of the premises, for the most part, ensured that each resident could enjoy living in an accessible, comfortable and homely environment. This enabled the promotion of independence,

recreation and leisure and enabled a good quality of life for the residents living in the centre.

There had been significant upkeep, repair and renovation to one of the house that overall led to positive outcomes for residents. A new kitchen had been fitted and new flooring in both the downstairs and upstairs areas of the house. The renovation works now meant that since the last inspection, the measures in place for infection prevention and control were now effective in keeping residents' safe.

There were further planned works for the bathroom in the apartment attached to the house. To meet the changing physical needs of the resident, there was a plan and schedule in place for a wet-room shower and toilet facility to be installed.

Since the last inspection, a resident had been supported to move from one of the centre's houses to a single occupancy apartment which meant that the designated centre's premises was now meeting their assessed needs. In addition, it was also ensuring a safer environment for residents who were living in the house the resident moved from. The resident told the inspector that they were happy in their new home and in particular, their bedroom.

Overall, the inspector found that residents' living environment provided appropriate stimulation and opportunity for the residents to rest and relax. In one house, the layout and decor of the sitting room had been improved since the last inspection. The room had been painted and decorated with a comfortable couch, a large television, framed pictures, soft furnishing and lighting.

Residents' expressed themselves through their personalised living spaces. The residents were consulted in the décor of their rooms which included family photographs, posters, pictures, memorabilia that were of interest to them. The inspector observed that one of the residents, who showed the inspector their bedroom, seemed proud and happy with the décor of their room and in particular, their array of music memorabilia that was important to them.

There were a number of upkeep and repair works observed on the day of the inspection and these are discussed in details under regulation 27. In addition, where one of the house's garden was not fully accessible to all residents, this has been addressed under regulation 9.

Judgment: Compliant

Regulation 26: Risk management procedures

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

There was a risk register in place in the centre and associated risk assessments which were reviewed on a regular basis.

Where there were identified risks in the centre, as well as risks that were specific to residents' individual health, safety and personal support needs, the person in charge was striving to ensure that appropriate control measures were in place to reduce or mitigate any potential risks. There were also risk assessment and measures in place for centre-based risks.

However, the inspector found that the high level of non-compliance found on the day of the inspection meant that until the centre came back into compliance, the provider could not be ensured that current measures in place were effective in mitigating risks in the centre. In particular, in the area of governance and management, medication management and safeguarding.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The inspector found that, for the most part, the IPC measures were effective and efficiently managed to ensure the safety of residents.

The inspector reviewed training schedules that demonstrated staff had completed specific training in relation to infection, prevention and control and overall, most of staff refresher training was up-to-date.

The centre was observed to be clean and cleaning records demonstrated a satisfactory level of adherence to the cleaning schedules. However, in one unit there had been no oversight of cleaning records or local infection prevention and control audits completed since January 2026.

In each of the units the inspector observed appropriate cleaning equipment and products and observed them to be stored appropriately. There was a colour coded mopping systems in place that ensured effective infection prevention and control measures were in place when cleaning the centre's floors.

However, the following areas required addressing to ensure infection prevention and control measures were effective in keeping the residents safe at all times;

- water-damage had led to a raised hall floor and mould malodour in the apartment within the centre
- in one of the houses, a toilet was observed to have no toilet seat cover. The paint on the seat was observed to be coming off and required replacing
- in the apartment attached to one of the houses, the inspector observed a number of cracks on the paintwork on the walls in the hall, sitting room and resident's bedroom. In the same apartment, a number of the cupboards and drawers in the kitchenette were observed unclean

- in one of the houses, the food hygiene system in place to label open food packages in the residents' fridge was not effective. The inspector observed open packets of cheese, chicken, coleslaw and garlic bread to be opened with no date of open label. This presented a risk to residents eating out of date food it also meant that the provider could not be sure that all food in the residents kitchen was safe to eat at all times.

There were two new breathing equipment machines in place to support the health needs of a resident. The inspector was shown the breathing equipment's cleaning sheet and checklist on the computer. The sheet provided instructions to guide staff on how to effectively clean parts of the equipment on a daily, weekly and monthly basis. However, the cleaning sheet had not yet been implemented and as such was not being adequately followed by staff. On speaking with one staff member, they advised the inspector that the machine was been cleaned once a week. Overall, this meant that the provider could not be assured that the equipment was hygienically clean and safe for the resident to use.

Judgment: Not compliant

Regulation 28: Fire precautions

Overall, the registered provider had failed to ensure that there was effective fire safety management systems in the designated centre that ensured the safety of residents and staff in the event of a fire.

Fire evacuation plans and resident personal evacuation plans were in place for staff to follow in the event of an evacuation. The plans were in place to provide clear guidance to staff to ensure a timely evacuation in the case of fire. However, not all personal evacuation plans were reviewed or updated as regularly as required which impacted on their effectiveness in keeping residents and staff safe at all times. For example, where one resident was refusing to evacuate in one of the houses, measure in place to support the resident evacuate and reduce the associated risks, had not been updated in their personal evacuation plan.

On review of one of the fire safety logs in one of the units (apartment) the inspector saw that there had been two occasion where the fire alarm had been activated. On one occasion, the service company was contacted to follow-up on the issue however, there was no outcome noted. These incidents had not been escalated to the person in charge or senior management at the time, which meant that the incidents had not been adequately followed up or notified as required and overall, posed a potential risk to the resident living in the apartment.

On the day of the inspection, during a walk around of one of the units (apartment), the inspector observed a rubber door stopper on the ground in the hallway. The inspector was advised that staff had been instructed to use the stopper to hold the bathroom door open to air out the malodour from mould. Overall, this meant that

the effectiveness of fire containment arrangements in the apartment was compromised and posed a potential risk to the resident's safety.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that the provider had failed to ensure there were appropriate oversight systems in place to ensure safe medication practices and to ensure their effectiveness, at all times. As such, some of the medication systems and practices in place, posed a potential risk to the residents' safety.

For the most part, there were appropriate systems in place for the ordering, receipt and prescribing of medicines. However, deficits were found in areas relating to the storing, disposal and administration of medications which posed a potential risk to the safety of residents.

On review of three residents' medication administration recording sheets (MARS) the inspector saw the while the medication had been administered, it had not been recorded on their individual MARS. This meant that with no record of the medication been administered, there was a potential risk of the resident receiving a dosage of the same medication twice.

A review of the labelling and oversight systems in place, to monitor the expiry date of medications, was needed. The inspector observed that where medicines expired sooner than the actual expiry date, (once opened), that this was not recorded on the medicine's label. The inspector observed in the medication cupboard in one of the units, that two liquid medications and one medication cream had been opened. They had not been provided with a label or system to say when they were opened and when they were due to expire, once opened. As such it was difficult to ascertain if the medication was still in date. In addition, there was a potential risk to residents' health should the medication be administered.

There was a local stock take and auditing system in place to ensure good oversight and the safety of each resident's medication. However, on review of the stock-take folder, the inspector observed that no stock take had taken place since 29th of May and there was no evidence of weekly audit since the beginning of June 2026. In addition, the house's daily duty list for the month of June 2026, which monitored the stock take and auditing system, had not been effective in identifying this gap. Overall, this demonstrated the lack of oversight and monitoring of residents' medication and meant that the provider could not be assured that the systems in place to keep residents' medication safe were effective.

Furthermore, on observing the medication cupboard, the inspector observed it to be cluttered and overloaded. While all residents were provided their own shelf space, the space was very small and not sufficient to hold each resident daily and PRN medication so that it was laid out clearly and easily accessible. One resident was

provided with two different shelves as they had been prescribed a high amount of PRN medication. However, the cupboards and boxes with it, were observed as untidy, overloaded and difficult to navigate. This practice posed a potential safety risk to the resident concerned and overall, was not in line with best practice.

There was a space underneath the medication cabinet for staff to prepare medications to be administered as well as record medications' administered to residents. The inspector observed the space to be cluttered with files and papers and overall, was not conducive to a sterile and appropriate area to prepare the residents' medication or to record same.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents were provided an 'all about me' assessment which included areas such as communication, sensory, behaviour, feeding eating and drinking, health and nursing supports, mobility, skin, personal care and dressing, physical skills, money support, transport support and sleeping. Residents personal plans also included risk assessments, rights assessment, personal evacuation plans, hospital and financial passports.

Following on from assessments, care plan supports were put in place for each resident to maximised their personal development in accordance to their wishes, individual needs and choices.

On an annual basis, each resident was a provided a 'circle of friends' meeting. Residents, and where appropriate their family members, were consulted in the planning and review process of their personal plans.

The centre's unannounced six monthly review identified a lot of gaps in residents' personal plans. A number of actions were put in place to address the gaps and staff were provided additional hours to review and update the plans. The inspector saw that there had been a lot of traction on reviewing and updating each resident's personal plan. However, further work was required to ensure all residents' care plans, that guide staff in supporting residents, were up-to-date or relevant.

In addition, not all reviews of residents' personal plans were found to be effective. For example, not all residents' health related referrals were followed up in a timely manner. For example, one resident was waiting on an occupational therapist appointment since 2025 to support their communication needs. On the day of the inspection, there was no evidence to demonstrate that there had been any further follow-up regarding the referral. The timeliness for the resident to receive an appointment was not satisfactory and overall meant that the provider could not be assured that the resident was supported to communicate in a way that best met their needs, likes or preference.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Overall, the provider and the person in charge promoted a positive approach to behaviours that challenged. Where residents required a positive behaviour support plan there were in place for them. On review of two residents' positive behaviour support plan, the inspector saw that plans were reviewed by an appropriate professional and up-to-date. Plans provided clear guidance to staff on how to support residents' manage their behaviours and ensure their safety.

Where behavioural incidents occurred these were recorded on behaviour support incident report forms. However, the inspector found that the monitoring and oversight of forms and associated reports required improvement. This was to ensure that where behavioural incidents resulted in a safeguarding concern, that they were identified and appropriately followed up to ensure the safety of residents concerned.

There were a number of restrictive practices in place in the centre. There was a system in place where restrictive practices were approved and reviewed by the organisation's restrictive practice committee. However, the inspector found that not all restrictive practices were provided with an appropriate or timely review. For example, where a resident moved to a new home in 2025, a restriction of a locked cupboard with sharp utensils, that was in place to keep the resident safe in their previous home, was still in place in their new home and had not been provided with an adequate review.

As there had been no appropriate review or reduction plan in place for the restriction, this meant that the provider could not be assured that all restrictions were in line with best practice or they were the least restrictive for the shortest amount of time. This meant that the provider had not ensured or appropriately considered the resident's rights in this area and overall, was resulting in negative outcomes for the resident.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had failed to ensure that all residents were safe at all times and protected from abuse.

Overall, the inspector found that the oversight and monitoring systems in place had failed to identify a number of peer to peer safeguarding incidents that had occurred in one of the houses in the designated centre. As such the incidents had not been

screened, investigated or notified to the appropriate services. This meant that there was no follow up or appropriate safeguarding plan put in place to reduce the risk of similar incident occurring. As such, the provider had not ensured each resident's health, safety and wellbeing and overall, this was resulting in negative outcomes for residents living in this house.

On review of a behavioural incident report from January 2026 to June 2026 the inspector saw four peer to peer incidents that had occurred. The incidents related to residents shouting at another resident, screaming at a resident as well as the negative impact on residents who witnessed the incidents. As the peer to peer incidents related to the same residents, there was a likelihood of a trend emerging and meant that there a high risk of recurrence had not been identified.

In addition, as there was no safeguarding plans put in place after the incidents, to ensure appropriate measures were in place to keep residents safe and reduce the risk of recurrence, there was a further likelihood for similar incidents to occur again. This also meant that these incidents were not reviewed at staff team meetings to support shared learning and consistency in trying to mitigate the risk of further safeguarding incidents.

Overall, the lack of review and oversight over the systems that record peer to peer incidents was not effective in ensuring residents' safety and wellbeing, identifying trends or reducing the risk of recurrence.

Judgment: Not compliant

Regulation 9: Residents' rights

Overall, the inspector found that the provider had failed to promote residents' rights at all times. The provider had not ensured that residents right to a safe environment was promoted. In addition, the inspector found that systems in place, to ensure residents' right to a quality service, were not effective. Furthermore, residents' right to have their complaint followed up and responded to was not ensured. Overall, these failures were resulting in negative outcomes for residents living in the centre.

For example:

- the provider had not identified or followed up on four safeguarding incidents occurring in the centre. This was impacting on residents' right to live in a safe and secure environment
- due to the high levels of non-compliance found on this inspection, some of which related to safeguarding, safe medication management and fire safety, the provider was not ensuring that residents' right to a service that provided good quality care and support were met, at all times.

The provider was failing to ensure that the organisation's complaints policy and procedures in the centre were effective in promoting residents rights and ensuring

their voice was heard and responded to. For example, in one unit a resident had made three different complaints. One complaint was followed up however, there was no record of the resident being informed of the outcome of the investigation or of the resident's satisfaction of the outcome.

In addition, where two other complaints had been logged that related to the maintenance of the unit's vehicle and water damage from flooding, there was no information in the apartment's complaints log regarding follow up of the complaint or of any response provided to the resident. The damage from the flooding had further resulted in a fire safety risk. For example, a door being wedge open to air out the malodour of mould.

In relation to restrictive practices in place, the provider had not ensured that all restrictions were subject to an appropriate and timely review or provided with a reduction plan. This meant that the provider could not be assured that restrictive practices in place were adhering to best practice and promoting residents rights and overall the the least restrictive for the shortest amount of time were in place.

The garden space out the back of one house was not physically accessible to all residents. While some residents could enjoy the seating and pergola areas of the garden independently, this was not the case for all residents due to the inaccessibility of areas in the garden. While the provider had identified the issue they had not secured adequate funding to address this deficit. This meant that the provider was not promoting all residents' right to live in a home where all areas were accessible to them.

Overall, the inspector found that residents' rights were not considered or promoted at all times, and in particularly in terms of being safe, provision of quality care and support, and making a complaint.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ballybrack OSV-0002884

Inspection ID: MON-0050711

Date of inspection: 17/06/2026

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There has been a full review of the rosters. The Person in Charge and the social care leader of the are house are now inputting their hours on the roster to reflect their time spent in the designated centre. This learning has been shared across all Designated centres in Dublin Southeast Services. Timeline: 22/06/26 - completed There is ongoing recruitment for social care workers to fill the .5 vacancy. Timeline: 30/09/26 There is ongoing recruitment for relief social care workers and social care workers so that we can provide consistency for the residents when there is unexpected leave. Timeline: 30/09/26	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff are scheduled for mandatory training and will complete this over the coming months – this includes Safeguarding Training, Triple C Training, and First Aid Training. The Person in Charge will complete regular reviews of the training log to ensure that staff are scheduled for and complete training in a timely manner. Timeline: November 2026 A clinical nurse manager with experience using the BiPAP and CPAP machines will attend the team meeting to show the staff how to use and clean the machines appropriately. There is a written procedure in place detailing how to use and clean the BiPAP and CPAP machines, and a video of the training provided to staff to guide them in the use of same.	

There is log that will be completed by staff in the Daily Duty folder to evidence that the procedure has been followed. Timeline: (30/07/26)	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The oversight and monitoring systems have been reviewed and where required, changed by the Person in Charge. All incidents are now reviewed in a timely manner and notified to the regulatory body where appropriate within the determined timeframe. Timeline: 18/06/26 Completed The Person in Charge is documenting their hours accurately on the rota to reflect their time in the Designated Centre. Timeline: 22/06/26 Completed An annual audit schedule is in place for the Designated Centre (DC), and audits will be completed across all houses in this DC in accordance with this schedule. Six-monthly unannounced visits will continue as planned to provide independent oversight of service quality and regulatory compliance. To further strengthen governance and oversight, a peer audit process is being introduced whereby Persons in Charge (PICs) will undertake peer-to-peer audits across DCs. This initiative will promote consistency, shared learning, and the identification of areas for continuous quality improvement. Timeline: 15/10/26 The PPIM of the designated centre delivered a safeguarding workshop to all PICs and supervisors to strengthen their understanding of their responsibilities in relation to safeguarding and incident reporting. The workshop focused on the importance of reviewing and triangulating information from the National Incident Management System (NIMS), behaviour support documentation, and PSF1 forms to ensure that all potential safeguarding concerns are identified. This approach supports the timely recognition, assessment, and reporting of safeguarding incidents, ensuring compliance with organisational policies, national safeguarding procedures, and HIQA regulatory requirements. Timeline: 06/07/26 Completed All open medication now has a label on it indicating when it was opened and when it should be discarded. Timeline: 29/06/26 Completed All restrictive practices within the designated centre will be reviewed in line with the organisation's policy, Enabling Restrictive-Free Practices and Environments. Each restrictive practice will be assessed to ensure it remains necessary, proportionate, and is the least restrictive practise possible to meet the individual's assessed needs. All restrictive practice reduction plans will be reviewed and updated to ensure they include clear strategies for reducing or eliminating restrictions wherever possible. Timeline: 31/08/26	

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All restrictive practices within the designated centre will be reviewed in line with the organisation's policy, Enabling Restrictive-Free Practices and Environments. Each restrictive practice will be assessed to ensure it remains necessary, proportionate, and is the least restrictive practice possible to meet the individual's assessed needs. All restrictive practice reduction plans will be reviewed and updated to ensure they include clear strategies for reducing or eliminating restrictions wherever possible. Timeline: 31/08/26 The PPIM of the DC delivered a safeguarding workshop to all PICs and supervisors to strengthen their understanding of their responsibilities in relation to safeguarding and incident reporting. The workshop focused on the importance of reviewing and triangulating information from the National Incident Management System (NIMS), behaviour support documentation, and PSF1 forms to ensure that all potential safeguarding concerns are identified. This triangulation of incidents also ensures that any injury that requires notification on the quarterly reports is not missed. This approach supports the timely recognition, assessment, and reporting of incidents, ensuring compliance with organisational policies, national safeguarding procedures, and HIQA regulatory requirements. Timeline: 06/07/26 Completed The importance of logging when the fire alarm is activated in the fire register and notifying the PIC has been discussed at team meetings in each location. The PIC will also complete fire audits to ensure we are fully compliant in relation to fire precautions. Timeline: 29/06/26 Completed	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The PIC will ensure that all incidents are triangulated (National Incident Management System (NIMS)), behaviour support documentation, and PSF1 forms) to ensure that safeguarding incidents are reported in a timely manner. Timeline 06/07/26 Completed The PIC will complete quarterly fire audits to ensure there is effective governance in place to mitigate against the risk of fire. All personal evacuation plans will be reviewed and updated after a fire drill has taken place. Timeline: 29/06/26 Completed A weekly medication audit will be completed by staff when they are doing the medication stocktake. The purpose of this medication audit is to ensure that all medication have labels on them if they are open, there is no out of date medication in the medication cabinet and the medication cabinet is kept in an orderly manner. The PIC is responsible for reviewing these medication audits. The PIC will complete a medication audit quarterly in each area to ensure we are compliant with our medication policy. Timeline: 29/06/26	

Completed	
All restrictive practices within the designated centre will be reviewed in line with the organisation's policy, Enabling Restrictive-Free Practices and Environments. Each restrictive practice will be assessed to ensure it remains necessary, proportionate, and is the least restrictive practise possible to meet the individual's assessed needs. All restrictive practice reduction plans will be reviewed and updated to ensure they include clear strategies for reducing or eliminating restrictions wherever possible. Timeline: 31/08/26	
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: A new daily duty checklist folder has been put in place in all areas. These are now checked by management on a weekly basis and signed by the person in charge to confirm they have been completed. Completed The flooring that has water damage and is causing a malodor will be replaced by October 30th 2026 The toilet seats in both locations have been replaced. The cupboards and drawers in the apartment has been cleaned and this is now on the daily duty cleaning list. The apartment will be painted by the 30th of August 2026 All food is now labelled as soon as it is opened. Completed A cleaning protocol and accompanying cleaning record for the CPAP and BiPAP machines have been implemented and are now in use within the designated centre. All staff have been instructed on the required cleaning procedures and are completing the cleaning records in accordance with the protocol to ensure the equipment is cleaned, maintained, and documented consistently. Completed	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All personal emergency evacuation plans (PEEP) have been reviewed and contain all information to guide staff practice to support individuals safely evacuate the location in an emergency. Completed The person in charge will complete quarterly fire audits to ensure there is effective governance in place to mitigate against the risk of fire. All personal evacuation plans will be reviewed and updated after a fire drill has taken place. Timeline: 29/06/26 Completed	

The importance of logging when the fire alarm is activated in the fire register and notifying the person in charge has been discussed at team meetings in each location. The person in charge will also complete fire audits to ensure we are fully compliant in relation to fire precautions. Timeline: 29/06/26 Completed

The rubber door stopper has been removed and is no longer being used in this location. All staff have been reminded of the importance of never holding a fire door open. Timeline: 17/06/26 Completed

Regulation 29: Medicines and pharmaceutical services

Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

All staff are aware of the importance of signing the medication administration recording sheets (MARS). Where a staff does not sign the MARS this is recorded as a medication error, and the PIC meets with the staff member to complete the medication variance form in line with our policy. If there are two medication variances the staff is required to complete the refresher SAMS course. Oversight of the MARS sheets is now on the weekly duties for the PIC and the supervisor of the area. Timeline: 22/06/26 Completed

A weekly medication audit will be completed by staff at the same time as the weekly medication stock take. The purpose of this audit is to ensure that all opened medications are clearly labelled with the date of opening, that there are no expired medications stored in the medication cabinet, and that the medication cabinet is maintained in a clean, organized, and orderly manner. The PIC is responsible for reviewing the weekly medication audits and stock take records to ensure they are completed consistently and any issues identified are addressed promptly. Timeline: 29/06/26 Completed

In addition, the PIC will complete a comprehensive quarterly medication audit in each area of the DCs to monitor compliance with the organisation's medication management policy, identify any areas requiring improvement, and ensure that appropriate corrective actions are implemented and monitored through the DCs governance systems. Timeline: 29/06/26 Completed

A new, larger medication cabinet has been ordered for one of the houses within the DC to ensure there is sufficient storage capacity to maintain medications in a safe, secure, and orderly manner. The area surrounding the medication cabinet will be kept clear of clutter at all times to provide staff with adequate workspace for the safe preparation and administration of medications. The PIC will monitor compliance with these requirements through routine medication audits and governance oversight Timeline: 30/08/26

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: The PIC will continue to complete regular audits of the personal plans to ensure they are reviewed and updated in a timely manner and accurately reflect each residents assessed needs, preferences and goals. Timeline 29/6/2026 Completed The PIC has followed up on the referral to Occupational Therapy and will coordinate a multidisciplinary review to ensure the resident's assessed needs are comprehensively reviewed. Any recommendations arising from the multidisciplinary review will be incorporated into the resident's personal plan. Timeline 30/08/26	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The PPIM of the DC delivered a safeguarding workshop to all PICs and supervisors to strengthen their understanding of their responsibilities in relation to safeguarding and incident reporting. The workshop focused on the importance of reviewing and triangulating information from the NIMS, behaviour support documentation, and PSF1 forms to ensure that all potential safeguarding concerns are identified. This triangulation of incidents also ensures that any injury that requires notification on the quarterly reports is not missed. This approach supports the timely recognition, assessment, and reporting of incidents, ensuring compliance with organisational policies, national safeguarding procedures, and HIQA regulatory requirements. Timeline: 06/07/26 Completed All restrictive practices within the designated centre will be reviewed in line with the organisation's policy, Enabling Restrictive-Free Practices and Environments. Each restrictive practice will be assessed to ensure it remains necessary, proportionate, and is the least restrictive practise possible to meet the individual's assessed needs. All restrictive practice reduction plans will be reviewed and updated to ensure they include clear strategies for reducing or eliminating restrictions wherever possible. Timeline: 31/08/26	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The PPIM of the designated centre delivered a safeguarding workshop to all PICs and supervisors to strengthen their understanding of their responsibilities in relation to safeguarding and incident reporting. The workshop focused on the importance of	

reviewing and triangulating information from the NIMS, behaviour support documentation, and PSF1 forms to ensure that all potential safeguarding concerns are identified. This triangulation of incidents also ensures that any injury that requires notification on the quarterly reports is not missed. This approach supports the timely recognition, assessment, and reporting of incidents, ensuring compliance with organisational policies, national safeguarding procedures, and HIQA regulatory requirements. Timeline: 06/07/26 Completed The PIC and the PPIM did a full review of the BRFs and NIMS that occurred in this centre to ensure that all safeguarding incidents were identified. The safeguarding incidents have a corresponding safeguarding plan that has been discussed at the team meetings to ensure all actions are being followed up on. 29/6/2026 Completed	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The PPIM of the DC delivered a safeguarding workshop to all PICs and supervisors to strengthen their understanding of their responsibilities in relation to safeguarding and incident reporting. The workshop focused on the importance of reviewing and triangulating information from the NIMS, behaviour support documentation, and PSF1 forms to ensure that all potential safeguarding concerns are identified. This triangulation of incidents also ensures that any injury that requires notification on the quarterly reports is not missed. This approach supports the timely recognition, assessment, and reporting of incidents, ensuring compliance with organisational policies, national safeguarding procedures, and HIQA regulatory requirements. Timeline: 06/07/26 Completed All restrictive practices within the designated centre will be reviewed in line with the organisation's policy, Enabling Restrictive-Free Practices and Environments. Each restrictive practice will be assessed to ensure it remains necessary, proportionate, and is the least restrictive practise possible to meet the individual's assessed needs. All restrictive practice reduction plans will be reviewed and updated to ensure they include clear strategies for reducing or eliminating restrictions wherever possible. Timeline: 31/08/26 All complaints will be managed in accordance with the organisation's 'Have Your Say' Complaints Policy and within the timeframes specified in the policy. The PIC will ensure that complaints are acknowledged, investigated, responded to, and appropriately documented, with any learning identified informing service improvements where required. 29/6/2026 Completed The resident has been informed of the outcome of their complaints, and has been advised that, should the issue reoccur, they are entitled to make a further complaint for investigation. Completed The resident has also been updated regarding the repairs to their flooring and advised that we are waiting for a date for the work to replace the flooring. An application will be submitted to the Housing Finance Agency's Social Impact Fund to secure funding to improve the accessibility of the garden within the DC. The proposed works will enhance access for residents, promote greater independence and inclusion, and support residents to safely enjoy the outdoor environment in line with their	

individual needs and preferences. The PIC will monitor the progress of the application and, if funding is approved, oversee the implementation of the improvement works to ensure they are completed in a timely manner. Timeline for application submission: 30/07/26

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/09/2026
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	22/06/2026
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	Substantially Compliant	Yellow	30/07/2026

	development programme.			
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	30/11/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	29/06/2026
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections	Not Compliant	Orange	30/10/2026

	published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	29/06/2026
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	29/06/2026
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	22/06/2026

Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	30/08/2026
Regulation 31(1)(c)	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 fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.	Substantially Compliant	Yellow	29/06/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing	Not Compliant	Orange	29/06/2026

	within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
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 procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	29/06/2026
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.	Substantially Compliant	Yellow	30/08/2026
Regulation 07(4)	The registered provider shall	Substantially Compliant	Yellow	31/08/2026

	ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	31/08/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	06/07/2026
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	31/08/2026