



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

Issued by the Chief Inspector

Name of designated centre:	Sallynoggin D.C.
Name of provider:	St John of God Community Services CLG
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	03 June 2026
Centre ID:	OSV-0002890
Fieldwork ID:	MON-0045671

About the designated centre

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

This designated centre is comprised of two individual houses located next door to each other in a suburban South County Dublin area. Each house consists of five individual residents' bedroom, a kitchen, dining room, a sitting room and shower and toilet facilities. Both houses include a garden to the back of the premises. The centre provides a residential service to ten adults with a disability. There is a person in charge appointed to manage the centre. They are also the person in charge of two other designated centre located nearby. They are supported in their role by a social care leader and report to a senior manager. The staff team comprises of one nurse, and social care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9
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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 3 June 2026	10:00hrs to 17:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over the course of one day 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.

On the day of the inspection, the person in charge was not available and the social care leader, who supports the person in charge in their role, was on annual leave. The inspection was facilitated by the residential programme manager, who is also the person participating in management (PPIM) for this centre. The inspector used observations and discussions with management, staff and residents, in addition to a review of documentation, to form judgments on the residents' quality of life.

On arrival at the centre the inspector provided the staff with a 'nice to meet you' document to share with the residents. 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 inspector found that the provider and person in charge were endeavouring to ensure that each resident's health, well-being and welfare was maintained by a good standard of evidence-based care and support. The provider, person in charge and staff promoted an inclusive environment where each of the resident's needs, wishes and preferences were taken into account. Overall, there were good levels of compliance found on this inspection. However, some improvements were needed to the following areas, staffing, infection prevention and control (IPC), medication management, fire safety, personal plans and residents' rights. These are discussed in detail under the associated regulations.

The designated centre consisted of two houses and was registered for ten residents. At the time of the inspection, there were nine residents living in the centre. The inspector was provided the opportunity to meet eight of the nine residents. There were five residents living in one house and on the day, one of the residents was staying with their family for the week. There were four residents living in the other house.

Currently a resident from another designated centre, run by the provider, was undergoing a compatibility assessment to see whether this centre was suitable for them to move in to. Over the past six weeks, they attended the centre two evenings a week to have dinner with the current residents as well as a few hours on Saturday or Sunday to participate in community activities. Accounts of each visit were recorded by staff as part of the compatibility assessment. A meeting was planned to

discuss the outcome of these visits to assess suitability and to ensure the safety of all residents concerned, should the resident choose to move to this location.

Residents were supported by a staff team which consisted of a staff nurse and social care workers. From speaking with staff, the inspector found that they were familiar with the needs of residents and the supports required to meet those needs. The inspector found that staff were also aware of each resident's personality and of their uniqueness and different abilities.

Most of the residents living in the centre primarily engaged through verbal conversations. However, where appropriate, staff provided prompts and cues to support engagements between residents and the inspector.

On the morning of the inspection, the inspector completed a walk around of the centre. The first house consisted of a large sitting room that was welcoming and presented as homely. There were framed photographs of each of the residents on the fire place mantelpiece, there were large glassed encased candles and a flower bouquet to the front of the fire place. The inspector observed comfortable couches and armchairs, a large television and paintings on the wall. There were two armchairs that required upkeep however, the inspector was informed that two new arm chairs had been purchased and that the old chairs were due for removal that week.

There was a dining room with a large dining table and chairs. Part of the room was also used as an office space with a desk, laptop and large printer. Overall, this took away from the homeliness of the room. In addition, having the office in this location posed a risk of personal identifiable information being left out in a communal space. On the day, the inspector observed a number of documents that were personal in nature stored out loosely on the desk beside the printer. There were also open boxes of paper and folders observed on the ground and again, residents' personal information was observed to be within the boxes. This is discussed further under Regulation 9.

The kitchen was observed to be in good upkeep and repair and observed to be clean and tidy. There was a small shed out the back of the kitchen for the laundry machines. The room was observed as clean however, some upkeep was needed to the flooring. This was to ensure it could be cleaned effectively, in terms of IPC.

One resident was provided with a downstairs bedroom. This was to support their assessed physical needs. There was also an accessible downstairs shower and toilet facility. However, on observing the shower fixtures such as the tray, shower unit and curtain, the inspector saw that it required a deep clean.

Upstairs there were four residents' bedrooms. The inspector observed them all to be well maintained and clean and tidy. Each room was observed to be unique to the resident and included items that were personal to them such as framed family photographs, soft furnishings, soft toys, board games, compact discs, medals and trophy's which residents had been awarded. There was a shower and toilet facility upstairs which was observed as clean and well maintained.

The second house which was next door and was of similar layout however, just off the dining room there was another small sitting room. This was used for residents to take time out and relax in. The kitchen was observed to be clean and tidy and the sitting room to be comfortable and welcoming with an array of photographs of residents enjoying community activities with their peers and family members.

There was a resident's bedroom, accessible shower and toilet facility and a single toilet in the downstairs section of the house. There were four residents' bedrooms upstairs, one was vacant. The inspector observed that each of the bedrooms were unique and personal to the residents and were in good upkeep and repair. Both shower and toilet facilities upstairs and downstairs were observed to be clean and in good upkeep and repair.

There were large notice boards on the walls of both house's dining rooms. They contained a lot of information that was informative and of interest to residents. All resident's day service activity plans were displayed on the boards, which showed what activities resident were due to attend on a daily basis. There was also information about the provider's complaints' procedures, the designated officer as well as photographs and contact details of related officers. There was information on upcoming community events as well as details of staff working on each day of the week. However, the inspector found that some of the information on the notice boards were personal to some residents and overall, was not promoting their right to privacy and dignity.

Outside the back of both house provided a large garden space with garden furniture including a large table and chairs. One garden contained a large egg chair swing. The inspector was informed that this was part of one resident's achieved goals.

Overall, on review of feedback from the centre's annual report (March 2025 - April 2026) the inspector saw that residents and their family were happy with the care and support they were provided to residents. In addition, on speaking with residents on the day, the inspector found that residents views of their service was very positive in particular, in relation to their bedrooms, their staff and the house in general. On speaking with residents, the inspector found that they were aware of who they could speak with if they had an issue or were unhappy.

On return from their day services, a number of the residents were happy to take time out to speak with the inspector. Three residents were happy to show the inspector their individual bedrooms.

All residents said they were happy with their bedrooms. Residents pointed out different items in their rooms that were personal to them such as their favourite soft toys, framed family photographs, music compact discs and for one resident, a painting by their family member. One resident told the inspector that they had chosen their own bed covers.

While one resident was showing the inspector their room, they pointed out that the door closer devise was not working properly. This meant that their door could not be

kept open on its own. The person participating in management advised the inspector that they would follow up with the maintenance team to resolve the issue.

One resident pointed out their recently purchased large television. They told the inspector that they planned to watch their favourite programmes that evening. Staff informed the inspector that the resident had offered their old television to one of the other residents living in the same house.

With the support of their staff, all residents had created a photograph and picture form of a "My Vision" poster. They were placed in their bedrooms. The posters were all different in style and shape but overall, included each resident's likes and dislikes, important people in their lives and planned and achieved goals.

One resident told the inspector of their plans of an upcoming trip away. They said they were looking forward to strawberry picking in Wexford with two of their friends and their staff member. They appeared excited when talking about their plans and in particular, about going out for dinner afterwards.

The inspector observed interactions between residents in each of the houses; Residents appeared happy and relaxed in the company of each other. In one house the atmosphere was lively and jovial and in the other house, the atmosphere was quiet and relaxed.

The inspector spoke with four staff throughout the day, and spoke in detail with two of the staff. The inspector found they were very knowledgeable about the residents' needs and the supports required to meet their needs. Staff advocated on behalf of residents and supported them to talk about and raise issues that mattered to them.

Residents were provided weekly household meetings. The inspector found that residents were encouraged and supported around active decision making and social inclusion. The meetings provided a space for residents to make choices about their weekly menu plan, about their activities and also matters that were important to them. The agenda and minutes were provided in easy-to-read format with a photograph of each of the residents on the front page noting their attendance. The last page of the meeting minutes noted residents' agreement (or not) to what had been discussed and decided.

On review of the two of the most recent meeting minutes, the inspector saw that a discussion about respecting people's private spaces was discussed. In particular, residents were reminded not to enter other residents' bedrooms without permission, or to take items from other residents' bedrooms. This discussion was part of an interim safeguarding plan where actions included a discussion with residents on respecting people's personal spaces and property.

Residents were supported to engage in meaningful community activities through their day service as well as residential service. While residents enjoyed participating in group activities, they were also supported to attend activities that were meaningful to them on a one to one basis. The provider had staffing arrangements in place, (double cover), to support this. Each resident was allotted one evening per

week where they were supported on a one to one basis with their key worker to part-take in an activity that was meaningful and of preference to them.

In summary, the inspector found that each resident's well-being and welfare was maintained to a good standard and that there was a strong and visible person-centred culture within the designated centre.

However, some improvements were needed to staffing, IPC, fire safety, personal plans and residents' rights to bring the centre into full compliance.

These matters are discussed further in the next two sections of the report which present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, the findings of this announced inspection were that residents were in receipt of a good quality and safe service, with good local governance and management supports in place. However, under capacity and capability, some improvements were needed to staffing, training and development and policies and procedures.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a person in charge, supported by a social care leader and a staff team of social care workers and one nurse. The person in charge was employed to work full-time but divided their working hours between this designated centre and two other designated centres.

The provider was endeavouring to ensure that there were sufficient suitably qualified and experienced staff on duty to meet residents' current assessed needs. However, there were currently two staff vacancies in the centre which potentially impacted on continuity of care provided to residents.

The education and training provided to staff enabled them to provide care that reflected up to date, evidence-based practice. However, some improvements were needed to ensure all refresher training was up-to-date. This was to ensure that staff

were provided with the necessary skills and training to deliver quality, safe and effective services that catered for each resident's assessed needs.

The inspector found that staff were in receipt of regular, quality supervision, which covered topics relevant to service provision and their professional development.

The provider had effective systems in place to monitor and audit the service. An annual review of the quality and safety of care had been completed and six-monthly unannounced visits to the centre were also being carried out. On completion of these audits, actions required were transferred over to the centre's quality enhancements plan for the person in charge to follow up on and address issues identified, in a timely manner.

For the most part, the inspector found that governance systems in place ensured that service delivery was safe and effective through the ongoing auditing and monitoring of its performance resulting in a thorough and effective quality assurance system in place. Where some monitoring anomalies were found, these have been addressed under the associated regulation.

Regulation 15: Staffing

The provider was striving to ensure that there were sufficient staffing levels with the appropriate skills, qualifications and experience to meet the assessed needs of residents at all times, in accordance with the statement of purpose and the size and layout of the designated centre.

The staff team consisted of the person in charge, a nurse and social care workers. On the day of the inspection there were two social care worker vacancies for one of the houses in the designated centre.

The person in charge was endeavouring to ensure continuity of care and promote the development and maintenance of trusting relations. On review of the rosters between March 2026 and June 2026 the inspector saw that, while there had been a high number of relief and agency staff covering gaps in March, there had been a significant decrease in May and June. Permanent staff members, staff members from the centre's other house as well as previous employees were also covering shifts. This meant that, for the most part, residents were being supported and cared for by staff who were familiar to them. However, the inspector found that overall, continuity of care could not be ensured at all times while the staff vacancies remained in place.

During the inspection, the inspector spoke with and observed a number of staff members on duty and their interactions with residents; The inspector spoke in detail with two staff members and found that they were very knowledgeable about residents' support needs and their responsibilities in providing care.

The actual and planned rosters showed the staffing arrangements in the centre including staff on annual leave, training and other types of leave. However, improvements were needed to ensure that all relief staff full names were included on the roster. In addition, the roster had not included the new person in charge's hours on the roster. As such, the information on the roster did not clearly reflect management and staff on duty in the centre which meant that overall, the roster was not maintained appropriately at all times.

Judgment: Substantially compliant

Regulation 16: Training and staff development

On the day of the inspection, the inspector saw that the person in charge had systems in place to evaluate staff training needs and was striving to ensure that adequate training levels were maintained.

On review of the staff training matrix in place in the designated centre, the inspector saw that, for the most part, staff had completed organisation's mandatory training such as manual handling, safeguarding vulnerable adults, fire safety, dysphagia, safe medication management, infection and prevention and control, first aid and positive behaviour support.

A recent peer to peer audit, regarding staff training, had found high levels of staff training to be out-of-date. Since then there had been improvements and a number of staff training, as well as refresher training, had been completed. However, further improvement was needed. For example, a number of refresher training courses remained outstanding for some staff. For example: positive behaviour supports (two staff), infection prevention and control (two staff), dysphagia (three staff), first aid (four staff) fire safety (one staff).

The person in charge had ensured that one-to-one supervision meetings which support staff in their role when providing care and support to residents, had been scheduled for all staff. On review of the schedule the inspector saw, that, all staff had been provided with a one to one supervision meeting with the previous person in charge during the first quarter one of 2026.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, the governance and management systems in place were of a good standard in this centre. There was a clearly defined management structure that identified the

lines of authority and accountability, and staff had specific roles and responsibilities in relation to the day-to-day running of the centre.

The person in charge commenced their role in May 2026. They were covering for the previous person in charge while they were on a period of planned leave. The person in charge was responsible for three designated centres. They were supported by a social care leader to carry out their role in this designated centre.

In general, the provider's governance and management structure arrangements included the person in charge being responsible for a number of designated centres, that consisted of maximum six houses. However, as there was currently a social care leader vacancy in the two other designated centres that the person in charge was also responsible for, interim arrangements had been put in place. For example, the person in charge's remit currently included responsibly of three designated centre with a total of four houses. The inspector was informed that this arrangement would stay in place until a new social care leader was recruited and available to support the person in charge.

The provider had completed an annual review of the quality and safety of care and support in the designated centre between April to March 2026. There was evidence to demonstrate that residents and their families had been consulted in the review. In addition to the annual review, unannounced six monthly reviews had been completed in November 2025 and March 2026. This was to review the quality and safety of care and the support provided to residents every six months and included an action plan with allocated responsibilities and time scales was in place.

Furthermore, in March 2026 the annual fire safety audit had been completed. In addition, a health and safety audit had been completed, which included health and safety management systems, hazard identification and risk assessments as well as health and wellbeing. In April 2026, an infection prevention and control audit tool, a medication management audit, a safeguarding self-audit, as well an audit on the contents of residents' personal plan folders had been completed. Overall, the audit systems in place were effective in identifying issues and ensure quality improvements were put in place resulting in positive outcomes for residents. Where some small anomalies were found in checks relating to infection prevention and control and local fire safety systems, these have been addressed under the associated regulation.

Staff team meetings took place on a monthly basis. The new person in charge had attended the most recent meeting in May 2026. Overall, the inspector found that the meetings promoted shared learning and supported an environment where staff could raise concerns and talk about the quality and safety of the care and support provided to residents.

Judgment: Compliant

Regulation 31: Notification of incidents

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

The person in charge had ensured that all adverse incidents and accidents in the designated centre, required to be notified to the chief inspector of social services, had 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).

The inspector found that incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. Where there had been incidents of concern, the incident and learning from the incident, had been discussed at staff team meetings. For example, the inspector saw that where there had been a recent peer to peer safeguarding concern, this had been discussed at the most recent staff team meeting as well as the residents' household meeting. This was in a effort to share learning and mitigate the potential risk of a similar incident occurring again.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had established and implemented effective complaint handling processes. For example, there was a complaints and compliments policy in place and it was up-to-date. In addition, staff were provided with the appropriate skills and resources to deal with a complaint and had a full understanding of the complaint's policy.

The inspector observed that the complaints procedure was accessible to residents and in a format that they could understand. Residents were supported to make complaints, and had access to an advocate when making a complaint or raising a concern. From speaking with staff and a review of records, the inspector saw that the complaints procedures were regularly discussed with residents at their residents' household meetings to promote awareness and understanding of the procedures.

The person in charge was aware of all complaints and they were followed up and resolved in a timely manner, where possible. On the day of the inspection, there was no open complaint. The inspector reviewed two complaints that previously been submitted in January 2026 and May 2026 and found that they had been recorded and managed appropriately in line with the provider's own policy. The inspector saw that the complaints had been promptly followed up on and closed off within the same month they had been raised. Furthermore, satisfaction levels of the outcome of the complaints had been recorded in line with the regulatory requirement.

Judgment: Compliant

Regulation 4: Written policies and procedures

There were relevant policies and procedures in place in the centre which were an important part of the governance and management systems to ensure safe and effective care was provided to residents including, guiding staff in delivering safe and appropriate care.

However, on review of the centre's Schedule 5 policies, the inspector found that a number of policies and procedures had not been reviewed in line with the regulatory requirement time frame of every three years. While most of the out-of-date policies were under review the inspector found that until they were in date, the register provider could not ensure that all policies and procedures were consistent with relevant legislation, professional guidance and international best practice relating to delivering a safe and quality service.

Some of the following policies and procedures were currently under review, with some at the final stages of approval;

- medicines management policy for disability and community health services (due May 2025)
- stakeholder feedback and complaints policy (due November 2025)
- food safety policy and procedures (due July 2025)
- data protection and retention policy (due July 2025)
- provision of personal intimate care policy (due January 2024)

While there was a residents' guide in place, there was no policy in place for 'Provision of information to residents' as per the requirement of Schedule 5.

Judgment: Substantially compliant

Quality and safety

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

The management and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. Care and support provided to residents was of good quality.

However, to ensure better outcomes for residents at all times, improvements were required in relation to, residents' personal plans, IPC, fire safety, medication management and residents' rights.

On a walk around of both houses within the centre, the inspector observed the houses to be clean and tidy. Overall, the houses presented as warm and welcoming with a homely feel to them. Residents appeared comfortable in their environment and were consulted in the layout and design of their bedrooms.

There were infection, prevention and control measures and arrangements to protect residents from the risk of infection however, some improvements were required to meet optimum standards. For the most part, the inspector found that the infection, prevention and control measures were effective and efficiently managed to ensure the safety of residents. However, to ensure all areas of the centre could be cleaned effectively, improvements were needed to the upkeep and repair some of the facilities in one of the houses.

The inspector reviewed a sample of residents' personal plans. The person in charge ensured that there was a comprehensive assessment for each resident. A recent personal plan audit had identified a number of gaps within each residents' personal plan and work was in progress to address the issues. However, on the day, the inspector found that further work was needed. This was to ensure all residents' care and support plans were relevant and took into account any changes to residents' assessed support needs.

Every effort had been made to ensure that residents could receive information in a way that they could understand. Each resident was provided with a communication support plan that had been developed from a comprehensive individual communication assessment. The support plans were reviewed on a yearly basis or sooner if required.

The provider had ensured that the risk management policy met the requirements as set out in the regulations. There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre.

Residents living in the designated centre were protected by appropriate safeguarding arrangements. Staff were provided with appropriate training relating to keeping residents safeguarded. There were good oversight systems in place that ensured safeguarding policies and procedures were adhered to.

The restrictive practices used were clearly documented and were supported by appropriate risk assessments which were reviewed on a regular basis and were subject to review by appropriate professionals.

Suitable fire equipment was provided and serviced as required including the fire alarm, emergency lighting and fire fighting equipment. There were suitable means of escape and an up-to-date fire evacuation plan. Staff were trained in fire prevention and day and night-time fire drills and scenarios were completed. However, improves were needed to ensure that fire safety monitoring systems were

effective in identifying and addressing faults when they occurred. This was to ensure the safety of residents at all time.

Through speaking with management and staff, observations and a review of documentation the inspector saw how residents rights were promoted. For example, residents were provided choice and control in their lives and were supported to be active participants in making decisions about their lives and in the running of the centre. However, improvements were needed to ensure residents right to privacy, in relation to personal information, was promoted at all times.

Regulation 10: Communication

Residents living in the centre presented with a variety of communication support needs. Communication access was facilitated for residents in this centre in a number of ways in accordance with their needs and wishes.

All residents had been provided a communication assessment using the Triple C format and the outcome of the assessments then informed the support plan required for each resident. The plan guided staff in how to best understand and communicate with residents in line with the outcome of the assessments' symbolic established level. Improvements were needed to ensure that the plans were located in residents' personal plans however, this has been addressed under regulation 5.

Residents were supported to engage in household meetings on a weekly basis. At the meetings residents made choices and decisions about their meals, activities and matters that were important to them. The meetings took in to account residents different communication abilities and levels and where appropriate were adapted to take in to consideration each resident's Triple C communication level. Residents ticked or signed the easy to read meeting minutes if they had participated and understood the meeting.

Overall, speaking with staff members it was evident that they were aware of the communication supports that residents required and were knowledgeable on how to communicate with residents. Where further supports for one resident as well as additional guidance for staff were needed, a referral was made to the organisation's speech and language therapist in April 2026 with an appointment date pending.

Judgment: Compliant

Regulation 17: Premises

The designated centre consisted of two houses that were located next door to each other. Many of the required works that were referred to in last inspection related to a house that is no longer part of the designated centre. However, the inspector was

informed by the person participating in management, that all required works had been completed.

Overall, the inspector observed the physical environment of the two houses to be clean and for the most part, in good decorative and structural repair. The design and layout of the designated centre 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 both houses.

Residents expressed themselves through their personalised living spaces. The residents were consulted in the décor of their rooms which included family photographs, medals, trophies, family paintings and memorabilia that were of interest to each resident. 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 memorabilia and soft toys that were important to them.

The residents' living environment provided appropriate stimulation and opportunity for the residents to rest and relax. There was a large spacious sitting room in both houses with ample comfortable seating for residents to relax and enjoy watching television. One house included an additional sitting room that provided a space for residents take some time out and listen to music, if they so wished.

In addition, each house provided a large dining room with table and chairs to provide an option for residents eating their meals together. However, there were office facilities in both areas which overall, took away from the homeliness of the space and posed a potential risk to residents' personal information. This has been addressed under regulation 9.

Both houses included an accessible shower and toilet facility downstairs as well as another shower and toilet facility upstairs. All facilities were observed to be clean however, in one house, some upkeep was needed to the shower base, unit and curtain. This has been addressed under regulation 27.

Judgment: Compliant

Regulation 26: Risk management procedures

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

Where there were identified risks in the centre, the person in charge ensured appropriate control measures were in place to reduce or mitigate any potential risks.

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

Where there was a potential risk of the mismanagement of money the provider had ensured that appropriate measures were in place. For example, some of the measures included, finance policy in place, money counted daily, staff check receipts and amount entered on spreadsheet, social care leader and person in charge carry out quarterly finance audits and staff report any discrepancies.

Where there was a potential risk of medication errors the provider had put a number of measure in place to mitigate the risk. For example, some of the measures included, a medication policy in place which was read and understood by all staff. All medicines dispensed in medical tray from pharmacy. All staff provided safe medication management training and refresher medication training should staff required it. All medicine stored in locked press.

Where there was a risk of cross contamination of gluten free foods, the provider had ensured appropriate measures were in place to reduce the risk. For example, there was a care plan in place to guide and support staff, a resident had their own cupboard to store their gluten free products. Separate toaster provided for gluten free use. A resident was provided information on gluten free products as well as information on the associate gluten free symbol.

Judgment: Compliant

Regulation 27: Protection against infection

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

The inspector reviewed training schedules that demonstrated that, 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 that cleaning records demonstrated a satisfactory level of adherence to cleaning schedules. There were cleaning checks in place for all areas of the house. A specific day was assigned to cleaning one resident's bedroom each day of the week. There was also a cleaner employed to work in the centre for three hours one day of the week.

The inspector observed appropriate cleaning equipment and cleaning products and saw that they were stored appropriately. There was a colour coded mopping system

in place that ensured effective infection prevention and control measures were in place when cleaning the centre's floors.

An infection prevention and control audit had taken place in the centre in April 2026 and overall, demonstrated the effectiveness of the measures in place to protect residents. The audit had identified and put actions in place for a number of issues that were observed by the inspector on the day. For example, there were two badly stained armchairs and a floor mat that required replacing. In addition upkeep was required to the flooring in the laundry shed (in one house). However, the audit had not identified the issues related to the downstairs shower and toilet facility in one of the houses. The inspector observed black grime and mould around the base of the shower, on the shower unit on the wall and at the bottom of the shower curtain, all of which required addressing.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Overall, the designated centre had appropriate fire management systems in place. This included containment systems, fire detection systems, emergency lighting, and fire fighting equipment. These were all subject to regular checks and servicing with a fire specialist. The inspector saw that emergency lights, fire alarms, blankets and extinguishers were serviced by an external company within the required time frame, with the most recent service taken place in April 2026.

The inspector observed that fire exits were easily accessible, kept clear and well sign posted. All staff had completed fire safety training. Staff who spoke with the inspector on the day were knowledgeable in how to support residents to evacuate each of the premises in the event of a fire.

The person in charge had prepared fire evacuation plans and resident personal evacuation plans for staff to follow in the event of an evacuation. These were reviewed for their effectiveness during fire drills and reviews.

Regular fire drills were taking place, including drills with the most amount of residents and the least amount of staff on duty, as well as different scenarios. This was to provide assurances that residents could be safely and promptly evacuated. There was a schedule in place for four fire drills to be carried on during 2026, one of which included a night-time scenario. At the time of the inspection, one drill had been completed in March 2025.

The person in charge also completed a fire safety register audit on a quarterly basis. The audit reviewed matters related to staff training, fire drills, staff fire safety checklists, inspection of fire fighting equipment, emergency lighting, fire detection systems, staff induction, guidelines in residents' emergency evacuation plans and fire exits.

On review of the centre's fire safety folder, the inspector saw that the person in charge had ensured that daily and weekly fire checks were completed of the precautions in place to ensure their effectiveness in keeping residents safe in the event of a fire. However, a review of the checks that monitored the fire door closers was needed. On the day, one of the residents advised the inspector that a device, that kept their door open, was not working. This had not been identified on the weekly checks, where all doors are left open (using the device) to test if they close on sounding the alarm. As such a review of the effectiveness of this checking system was needed to ensure the safety of residents at all times.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

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

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

Staff were competent in the administration of medicines and were in receipt of training and ongoing education in relation to medicine management.

A member of the staff team showed the inspector the medication cupboard and the systems, protocols and processes in place for the safe management of medicine. The staff was knowledgeable on medicine management procedures and on the reasons medicines were prescribed.

The medication administration records also indicated that medications were administered as prescribed. There were also appropriate transfer records in place to clearly show when resident's medications left the centre, for example, during visits to their family home.

There were appropriate oversight systems in place to ensure safe medication practices and to ensure their effectiveness. There were low numbers of medicine errors recorded; Where there were errors, these incidents were recorded, reported and analysed and learning was fed back to the staff team to improve each resident's safety and to mitigate against the risk of recurrence.

Medicines management was audited regularly in order to provide appropriate oversight over medicine management. However, some improvements were needed to ensure that the oversight systems in place were effective at all times. In particular, to monitor medications, that once opened, were discarded in line with the medicine's instructions leaflet.

For example, in the medication cabinet in one of the houses, the inspector saw that a resident's skin cream and mouth gel, which had been prescribed in June 2025, had not been provided with an opening date. On review of the gel instructions, it noted to discard the gel within one month after opening. This had not been identified on the medication audit and meant that there was a potential risk that the gel was not effective or safe to administer.

Judgment: Substantially 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 and financial passports. I

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.

In March 2026, as part of shared learning from findings of and inspection in another designated centre run by the provider, senior management had arranged for a comprehensive personal plan audit to be completed in a number of designated centres. The audit for this designated centre, identified a large number of gaps in a number of residents' personal plans. On comparing the audit outcome against residents' personal plans on the day, the inspector saw that many of the gaps had since been addressed. However, further work was required as some gaps remained and in particular, to residents' care support plans. This meant that currently, not all residents' care plans, that guide staff in supporting residents, were up-to-date or relevant.

Residents were supported to create a 'vision board' that included their likes and preferences, people who were important to them and the goals they hoped to achieve. During the inspection, two residents pointed out their vision board to the inspector and appeared happy and proud when showing it.

Residents were supported to choose goals that were meaningful to them, included them in their community and were in line with each of their likes and preferences. Residents were supported to progress their goals through key working sessions with their staff members. However, some improvements were needed to ensure that all key workings sessions were recorded in residents' personal plans. This was to

ensure that progress made by each resident was acknowledged and overall, supported them in achieving their goals.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

On the day of the inspection, no resident was assessed as requiring a positive behaviour support plan. Where there had been a reactive strategies plan in place for one resident, this was no longer required since their move to the designated centre. This was due to the fact that previous presenting behaviours had not arisen in their new home.

There were a small number restrictive practices implemented in the centre. The inspector saw where restrictive procedures were being used, they were based on centre and national policies. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals involved in the assessment and interventions with the individual.

All restrictions had been approved by the organisation's equality and human rights committee. The rationale for restrictions in place were clear and overall, the inspector found that restrictive practices in use were deemed to be the least restrictive possible for the least duration possible.

On review of a sample of residents' personal plans, the inspector found that residents were supported to understand and give consent for restrictive practices in use.

Judgment: Compliant

Regulation 8: Protection

The residents were protected by practices that promoted their safety. There was a clear policy in place with supporting procedures, which clearly directed staff on what to do in the event of a safeguarding concern.

There was good oversight over safeguarding measures in place. For example, the person in charge had recently completed a safeguarding self-auditing tool to assess adherence to national safeguarding policy and if any actions were required. The outcome of the tool demonstrated that appropriate safeguarding system were in place.

All staff had received up-to-date training in the safeguarding and protection of vulnerable adults. Staff spoken with were familiar with reporting systems in place, should a safeguarding concern arise.

Where there had been safeguarding incidents in the centre, the person in charge had followed up, reviewed, screened, and reported the incident in accordance with national policy and regulatory requirements. The person in charge ensured that all incidents were discussed at staff meetings to ensure shared learning and mitigate the risk of recurrences. Matters relating to keeping safe and self-protection were also discussed at residents' household meetings.

The person in charge carried out checks of the residents' finances to ensure each resident's money was maintained appropriately. There were a number of local audits that provided good oversight over the residents' finances.

The provider and person in charge had put in place safeguarding measures to ensure 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 each resident's dignity and bodily integrity.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider and person in charge were striving to ensure that the centre was operated in a manner that respected residents' disabilities and promoted their rights.

Residents were provided with choice and were part of the decision making about their home that related to their weekly menu plan and household chores and layout and decor of their bedroom. Each week residents were supported to attend resident house meetings where their voice was listened to, their opinions were taken on board, choices were made and information that was important, shared with them.

Residents were provided with information to support their knowledge and understanding of their rights. In each of the houses, there were large notice boards with details of the organisation's complaints process, equality and human rights, advocacy, the designated officer and matters that was important and meaningful to them.

Residents' independence was promoted through different activities that promoted their independent living skills. Residents were supported engage in their community in meaningful ways through a variety of activities. In addition, residents were support to be involved in household chores to support their independent living skills and provide a sense of autonomy within their own home.

Residents were provided information in a format that they understood and that was in line with their assessed needs and was of preference to them. For example, residents were provided information regarding the personal plan, goals, rights, safety, finance, meals and activities in easy-to-read and social stories formats.

Staff were provided human rights training to inform their practice and to support them deliver a person centred service to each resident living the centre.

A rights awareness check list had been carried out for each resident and was included in their personal plan. For example, the checklist reviewed the supports and care provided to residents to ensure their rights were promoted in all areas. The checklist included areas such as restrictive practices, residents' belongings, access to the environment, diet choices, budget and money, privacy and dignity, social opportunities and daily choices.

For the most part, documentation such as residents' personal plans and the information within them were kept securely in the staff office. However, the inspector found that improvements were needed to ensure that residents' right to privacy was respected, in terms of personal information. On walking around the two houses the inspector observed some residents' personal information, which contained financial, health care, medical, personal intimate care and personal identification details, were left on a desk or in open boxes in communal spaces. This meant that residents' right to privacy, in relation to their personal information, was not respected at all times and in some cases posed a risk to their security in terms of financial or personal identification information.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sallynoggin D.C. OSV-0002890

Inspection ID: MON-0045671

Date of inspection: 03/06/2026

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: Ongoing recruitment is taking place. A Part time staff is commencing in July 2026 which will bring the vacancies down to 1.5 WTE in the DC. We will continue to recruit and will use familiar relief staff for vacancies to maintain consistency and continuity of care for the residents. October 31st 2026. The roster has been reviewed by the PiC and the SCL and the full staff names and grades of staff are included on the roster. The person in charge is recording her hours on the roster and will continue to do so going forward. - complete	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in charge has reviewed the training log and all staff have been signed up for their training that was out of date: Positive Behaviors support Training – all staff will have completed by: August 31st Infection Prevention Control - all staff have been completed by: August 31st 2026 Dysphagia – all staff will have completed by: 21 September 2026 First Aid Training will be completed by: 21st October 2026 Fire Safety will be completed by: 15th July 2026	

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Schedule 5 has been updated with all reviewed policies. As the policies are reviewed and disseminated the PiC will ensure these are reviewed with all staff members and updated in the schedule 5 folder in the DC. The following policies are under review • medicines management policy for disability and community health services (due May 2025) – Person Centred Medicines Management Policy has been revised and updated and has been sent to Services for final comment – This will be approved by the end of July and disseminated to all staff – July 2026 • stakeholder feedback and complaints policy (due November 2025) – This has been approved and circulated to all staff on the 18th of June 2026 • food safety policy and procedures (due July 2025) – this is currently being updated and will be finalised by the end of September 2026 • data protection and retention policy (due July 2025) –This has been scheduled for review and will be finalised by end of September 2026. • provision of personal and intimate care policy (due January 2024) – this policy has been updated and will be going to Services for final comment. This will be circulated to all staff by the end of July 2026. The Person in charge will link with the quality team in relation to devising a policy on the provision of information to residents. This will be complete by December 31st 2026. We will continue to support residents in line with their triple C profile and ensure that we provide information for the residents in the format that is accessible to them.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: All staff will have completed their IPC training by August 31st 2026 The armchair has been removed by maintenance and the second armchair has received a deep clean – complete The old mat has been disposed of and a new mat has been purchased - complete The shower has received a deep clean and the grime and mould has been removed. This is part of the cleaning checklist and we have requested that household do a deep clean on this shower as part of the household duties. A new shower curtain has been bought - complete The floor in the shed has been raised with maintenance who will ensure that the works are carried out so that the floor is easily cleaned in line with IPC measures. – October 31st 2026	

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire door has been fixed – complete The fire drill has taken place and there is a schedule in place for the rest of the year. - Complete	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The weekly medication audit is being completed to ensure that all the medication cabinets are not overstocked, and labels are on all open medication - complete All open medications have been discarded and medicines are now being labelled once opened – the importance of same has been discussed with the staff team - complete	
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: All personal plans have been audited and there's a defined deadline in place for all care plans to be up to date. All plans are currently being reaudited and all plans will be updated by the end of July 2026 All monthly keyworker meetings are being recorded by the persons keyworker and the importance of same was discussed with all of the team. June 2026	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: All personal information has been removed from communal areas and the importance of respecting the privacy of all resident information was discussed with the team. The Person in Charge and the Social Care Leader will continue to monitor the houses to ensure no personal information is left in communal areas - complete The person in charge will link with maintenance to explore if the office can be moved upstairs to the staff sleepover room – July 30th 2026	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(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	31/10/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	21/10/2026
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are	Substantially Compliant	Yellow	31/10/2026

	protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	18/06/2026
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.	Substantially Compliant	Yellow	25/06/2026
Regulation 04(3)	The registered provider shall review the policies	Substantially Compliant	Yellow	31/12/2026

	and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
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	31/07/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	30/07/2026