Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Ardmore
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	07 January 2026
Centre ID:	OSV-0002353
Fieldwork ID:	MON-0044852

About the designated centre

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

Ardmore is a designated centre operated by St. Michael's House. It is located in a North County Dublin suburb. The centre caters for the needs of six adults with an intellectual disability. The centre comprises a two-storey detached house which offers each resident their own bedroom, shared bathroom facilities, sitting rooms, a kitchen and dining area, utility and garden area. The centre is located close to public transport, shops and amenities. The centre is staffed with a team of social care workers and is managed by a person in charge who in turn reports to a senior manager..

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 7 January 2026	10:00hrs to 17:45hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor ongoing regulatory compliance in the designated centre. It was carried out as part of the regulatory monitoring of the designated centre.

The inspection was facilitated by the person in charge for the first half of the day and by the centre's senior service manager for the remainder of the inspection. The inspector used observations and discussions with residents, in addition to a review of documentation and conversations with key staff and management, to inform judgments on residents' quality of life in the centre and the provider's compliance with the regulations.

Overall, the inspector found that the person in charge and staff were striving to ensure that residents living in the designated centre were provided with a quality and safe service. The inspector observed that the residents, and where appropriate their families, were consulted in the running of the centre and played an active role in the decision making within the centre. The person in charge and staff team empowered residents to live their life as independently as they were capable of.

On the day of the inspection, the inspector was provided the opportunity to meet with all residents living in the centre. Three resident chose to speak with the inspector on a one to one basis to relay their views. One of the residents who spoke with the inspector relayed their unhappiness about the behaviours of one of their house-mates.

On speaking with management and staff about the compatibility issues, the inspector was informed of a number of planned measures to address the issue. The measures were in attempt to reduce the risk of further safeguarding incidents occurring in the house. These measure are discussed further under the quality and safety section and Regulation 8 of the report.

Residents also spoke to the inspector about positive experiences in their home. One resident said that they 'loved their bedroom' and that staff were very supportive and kind to them. They said they could talk to management and staff at any time. Another resident said they liked the food available to them and that they enjoyed helping out at meal-times. One resident said that they enjoyed completing household duties in the house such as emptying and filling the dishwasher, recycling, doing their laundry, washing up the pots and pans, and keeping their room clean.

One resident told the inspector that they did not want to live in the house. They would prefer to live in their previous home town and be supported as an independent living person. They said they were capable of looking after themselves and just needed some support with their bills. On speaking with the person in

charge, the inspector was informed that they were aware of the resident's preference and had discussed it with the resident. They advised that the resident often changed their mind regarding this preference, however, they had arranged for the resident to be included on the organisation's referrals list for alternative accommodation. The person in charge had also ensured that the resident was supported to engage with an advocate regarding their housing preference. However, to date the resident had refused to engage with the advocate.

One resident who used non-verbal communication met with the inspector in the dining room alongside their staff and management. Where appropriate, their views were relayed through staff advocating on their behalf and through staff prompting the resident with expressing their view. While in the company of the resident, a staff member told the inspector that the resident had recently celebrated their birthday and enjoyed a party in the house. The resident smiled throughout the conversation and appeared to understand and agree with what was being said.

Residents were supported to activity engage in their community and in ways that were meaningful to them. Four of the five residents attended a day service. One resident, who had the choice to attend a day service for one day, had declined to avail of the service.

On speaking with residents and on review of their records, the inspector saw that residents enjoyed a variety of community activities, courses and events. For example, one resident was part-taking in a garden course, one resident was provided private art classes in their home, another resident attended and art and literacy class in the community. Residents also attended bingo, sale of work and enjoyed going to cafes and restaurants on a regular basis.

Residents were supported to visit friends and family and where appropriate, empowered to travel independently using public transport. The inspector observed photographs of one resident who recently celebrated a milestone birthday. The resident appeared happy in the photographs. Many of the pictures showed the resident with their house-mates, family and friends at a local restaurant where the birthday party was celebrated.

The designated centre comprised of a detached two story house located in a suburb in North County Dublin. On walking around the premises, the inspector observed it to have a homely and welcoming atmosphere. For the most part, the physical environment of the house was observed to be clean and tidy. The design and layout of the premises ensured that each resident could enjoy living in a 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 designated centre.

The walls on the hallway included framed photographs of all the residents, past and present. The house provided the residents with a spacious open plan kitchen and dining area. There was a sitting room as well as a separate TV/relaxation room. The inspector observed some upkeep and decor was needed to the TV/relaxation room.

The centre included two separate bathing and shower facilities, a utility room, a storage room and an enclosed garden area to the rear of the house. The staff sleepover room had been changed to include an office space that comprised of a desk and large in-built storage cupboards for files and folders. There was a small enclosed garden out the back of the house that included a storage box for cleaning equipment such as colour coded mop buckets and handles, and a large shed for storage of cleaning and household items.

Residents expressed themselves through their personalised living spaces. The inspector observed residents' bedrooms to be personal to each resident and reflected their likes an interests. The residents were consulted on the décor of their rooms which included family photograph and personal photographs and collages, paintings, 'all about me' as well as individual goal posters and framed photographs, and a variety of memorabilia that was of interest to each resident.

However, the communal shower and bathroom facilities were observed to be poor state of upkeep and repair. This was impacting on the effectiveness of the infection prevention control measures in place, in particular, when cleaning these areas. This issue was also identified on the 2023 and 2024 inspection of the centre as well as many of the provider's own audits. Overall, the timeliness of the provider to complete the works was not satisfactory. This is addressed further in the report.

Residents were encouraged and supported around active decision making and social inclusion. Residents had participated in monthly residents' meetings up until November 2025. On speaking with staff and on review of the December 2025 staff meeting minutes, the inspector saw that residents' monthly meeting had been temporarily postponed due to the presenting tensions during meetings. There was a plan in place to carry out the meetings on a one to one basis with each resident during monthly key working sessions.

Residents were supported by a team of social care workers who were managed by the person in charge. On speaking with staff, the inspector found that they were familiar with the residents' different personalities and were mindful of each resident's uniqueness and different abilities. Staff advocated on behalf of residents and in particular, in relation to the compatibilities issues in the centre. Staff expressed their concerns about how the compatibility issue was impacting on some of the residents' daily lives. Staff also empowered residents to speak up for themselves regarding this matter and supported them in logging complaints and speaking with the inspector on the day.

In summary, the person in charge and staff were striving to ensure that each resident’s well-being and welfare was maintained to a good standard. The inspector found that, for the most part, there were systems in place to ensure residents were in receipt of good quality care and support. However, the on-going resident incompatibility issues were having a negative impact on residents' lived experience in their home and overall, their sense of safety.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how

these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

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

The centre had a clearly defined management structure in place which was led by a capable person in charge. The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs and the supports required to meet those needs.

The registered provider had completed an annual review regarding the quality of safe care and support provided to residents during 2024 and was currently compiling an annual report for service provision during 2025. Six-monthly unannounced visit had also taken place in the centre and a suite of audits, including a monthly data reports, that had been carried by the person in charge.

There were clear lines of accountability at individual, team and organisational level so that all staff working in the centre were aware of their responsibilities and who they were accountable to. There was a staff roster in place and it was maintained appropriately. There were no staff vacancies in the centre at the time of the inspection.

The inspector spoke with staff members throughout the course of the inspection. The staff members were knowledgeable on the support needs of residents. On observing management and staff engage with residents, the inspector saw that interactions were positive, kind and jovial.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. The person in charge regularly reviewed staff training needs and on the day, all staff training was found to be up-to-date.

There was appropriate information governance arrangements in place to ensure that the designated centre complied with all notification requirements.

The provider had suitable arrangements in place for the management of complaints and an accessible complaints procedure was available for residents in a prominent place in the centre. However, some improvements were needed to the recording of complaints to ensure the effectiveness of the procedures.

The previous two inspection of the centre had identified poor upkeep and state of repair in the centre's shower and bathroom facilities. The provider had not ensured that actions to complete the works were addressed in a timely manner, and as such the infection prevention and control risk related to these areas, remained on-going and potentially impacted on the safety of residents using these facilities.

Regulation 14: Persons in charge

The person in charge had commenced in their role in this centre in February 2025. They worked full-time in this designated centre only. Within their working week, the person in charge was allocated one administration day to ensure effective governance, operational management and administration of the designated centre.

The person in charge had the appropriate qualifications and skills and sufficient practice and management experience to meet the requirements of Regulation 14 and to oversee the residential service to meet its stated purpose, aims and objectives.

The person in charge was familiar with residents' needs and was endeavouring to ensure that they were met in practice. The inspector found that the person in charge had a clear understanding and vision of the service to be provided and, supported by the provider, was striving to foster a culture that promoted the individual and collective rights of residents living in this centre.

Judgment: Compliant

Regulation 15: Staffing

On the day of the inspection, the provider had ensured there was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents, at all times, in line with the statement of purpose and size and layout of the building.

The person in charge ensured that staff rosters were appropriately maintained. The inspector reviewed the planned and actual rosters for the months of December 2025 to February 2026. Rosters reviewed accurately reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night shifts.

There were no staff vacancies in the centre. Where additional staff were required to support staff leave, overall, the same two relief staff, who were familiar to the residents, were employed. During 2025, where a resident required additional healthcare supports near the end of their life, the provider and person in charge had

made arrangements for additional staff to be employed to ensure the resident's needs were met and in a safe and dignified way.

On the day of the inspection, the inspector spoke to two staff members in detail and found that they were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents. Staff were aware of each resident's likes and dislikes. The staff advocated for residents in relation to the ongoing compatibility issues in the house. In addition, from speaking with residents and on review of documentation, it was clear that staff had empowered residents to speak up about the negative impact their peer's behaviour was having on them.

The inspector observed that residents appeared relaxed and happy in the company of staff and that staff were respectful towards residents through positive and caring interactions.

The inspector reviewed a sample of five staff records and found that they contained all the required information in line with Schedule 2.

Judgment: Compliant

Regulation 16: Training and staff development

Effective systems were in place to record and regularly monitor staff training in the designated centre. The inspector reviewed the staff training records and found that staff had completed a range of training courses to ensure they had the appropriate levels of knowledge and skills to best support residents living in the centre.

Some of the training provided to staff included the following;

- Fire safety
- Safeguarding of vulnerable adults
- Positive behaviour supports
- Safe administration of medication
- Manual handling
- Epilepsy related training
- First aid
- Feeding, eating, drinking and swallowing (FEDS),
- Infection prevention and control (IPC).

The person in charge showed the inspector the staff supervision schedule place for February 2026. While there had been some gaps in providing supervision meetings to staff during quarter three and four of 2025, the person in charge had implemented a reflective practice and informal supervision system with all staff.

On review of a sample of related records and from speaking with staff, the inspector found that the system was positively received and beneficial to their practice. The

inspector was informed by the person in charge that they had planned to completed a supervision schedule for the remainder of 2026.

Judgment: Compliant

Regulation 19: Directory of residents

The person in charge had established and maintained a directory of residents in the designated centre and it was made available for the inspector to view. The directory had elements of the information specified in paragraph three of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

The provider had effective systems and processes in place, including relevant policies and procedures, for the creation, maintenance, storage and destruction of records which were in line with all relevant legislation.

The registered provider had ensured information and documentation on matters set out in Schedule 2, Schedule 3 and Schedule 4 were maintained and were made available for the inspector to view.

A new filing system, that included numbered and labelled folders had been implemented and ensured ease of access to records related to the care and support provided to residents including matters related to the administration and operation of the centre. On speaking with management and staff, they relayed positive comments about the new filing system and in particular, regarding ease of access in locating files, efficient system and overall, a more appropriate storage location.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place were found to operate to a good standard in this centre. The person in charge was assisted by two social care workers, who formed part of the local in centre management and supervision arrangements. This structure was in place to support the person in charge ensure

effective governance, operational management and administration of the designated centre on a day to day basis.

The provider had completed an annual report of the quality and safety of care and support provided in the designated centre during 2024. There was evidence to demonstrate that the residents and their families were consulted about the review. The provider was currently compiling the report for 2025, and residents had completed questionnaires to relay their views.

The provider was completing six monthly unannounced reviews of the quality of care and support in the centre, with each review including an action plan and time frame. The two most recent unannounced reviews were carried out in January and August 2025.

Monthly data reports were being completed with oversight from the person in charge. The inspector reviewed a sample from August to November 2025. The reports were used at management meetings between the person in charge and service manager to review issues arising and actions required.

Areas addressed in the reports included safeguarding referrals, trust in care screenings, incident report forms, complaints and compliments, restrictive practice and behaviour of concern, fire drills, the risk register, staff annual leave, supervision meetings, sick leave, mandatory training, notifications to HIQA and monthly infection prevention control checks.

The person in charge ensured that staff team meetings took place on a regular basis to provide staff an opportunity for reflection and shared learning. On review of the staff meeting in December 2025, the inspector saw that matters relating to the care and support of residents where discussed as well as health and safety, maintenance, budget, fire safety, quality, risk assessments, restrictive practices, infection prevention and control, training, safeguarding, drug errors and notifications, but to mention a few.

Safeguarding was a standing item on the agenda. There was a plan in place for the senior safeguarding social work practitioner and psychologist to join the January 2026 staff meeting to discuss the ongoing compatibility and safeguarding issues in the centre.

However, in relation to the centre's premises, the inspector found that the timeliness of the provider to complete upgrades on the communal shower and bathroom facilities was not satisfactory and overall, was posing a risk to the infection prevention and control measures in place. This has been addressed further under Regulation 17.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector found that the person in charge had ensured that there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The inspector found that overall, incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. Where there had been behavioural or safeguarding incidents, the incidents and learning from the incidents, had been discussed at staff team meetings which provided shared learning and mitigated the risks of recurrence.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had established a complaints procedure underpinned by a comprehensive policy. The complaints procedure and policy was available in an easy-to-read format and accessible to residents. A copy of the procedure alongside information on advocacy was located in a communal space in the centre.

From speaking with staff and a review of records, the inspector saw that the complaints procedures were regularly discussed with residents at their monthly house meetings to promote awareness and understanding of the procedures and to allow them a space to make a complaint if they so wished.

However, some improvements were needed to the recording of complaints. For example, on the day of the inspection, there was one open complaint that had been logged in September 2025. The complaint related to a resident's unhappiness regarding their peers behaviour towards them. The inspector was informed that the person in charge had addressed the matter and that the resident later decided to withdraw the complaint.

However, on review of the record, the inspector saw no evidence of follow-up from the complaint or of the resident's satisfaction levels on how the complaint was managed as required by the regulations and in line with the provider's own complaints policy and procedures..

Judgment: Substantially compliant

Quality and safety

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

The provider and person in charge were striving to ensure that a safe and quality service was delivered to residents living in this centre. For the most part, the findings of this inspection demonstrated that overall, the provider had the capacity to operate the service in compliance with many of the regulations reviewed. However, due to ongoing compatibility issues in the centre, a safe service could not be ensured at all times.

There was an increase in safeguarding incidents in the designated centre in 2025 compared to the previous year. On speaking with senior management, the person in charge and staff members, the inspector was informed that there were compatibility issues in the house which were impacting negatively on some of the residents. Residents also relayed their unhappiness about this issue and how it was making them feel afraid and upset. Senior management and the person in charge were actively implementing plans and measures to reduce the risk of further safeguarding incidents.

Following a recent safeguarding incident in January 2026, a safeguarding audit was initiated on the 06 Jan 2026 by the organisation's senior safeguarding social worker. The person in charge informed the inspector that a review of incidents during 2025 was due to take place to ensure that all incidents, that occurred during this period, were reported and followed-up appropriately and were in line with national safeguarding policy and procedures. The person in charge had arranged for both the organisation's senior safeguarding social worker and psychologist to attend the staff team meeting in January 2026 to discuss the compatibility issues in the house and review alongside safeguarding procedures.

However, despite these measures, the inspector found that there was an ongoing risk of peer to peer safeguarding incidents occurring in the centre. There was no appropriate safeguarding plan in place and risk assessments relating to safeguarding had not considered compatibility issues. Overall, the situation was resulting in negative outcomes for residents and in particular, making residents feeling unsafe in their home.

On a walk around the premises, the inspector observed the house to be cleaned and tidy. Overall, the house presented as warm and welcoming with a homely feel to it. Residents appeared comfortable in their environment and were consulted in the layout and design of their bedrooms. However, upkeep and repair was required to both shower and bathroom facilities in the house. On the day of the inspection, the bathrooms were observed to remain in disrepair and were impacting on the effectiveness of infection prevention control measures. This meant that there was risk of spread of healthcare infections in the house as there were areas in these facilities that could not be cleaned properly. The inspector was informed that the provider was planning to apply for a housing adaptation grant to finance the upgrade of the bathrooms however, this was at the very early stages and the application had yet to be submitted.

The provider had ensured that the risk management policy met the requirements as set out in the regulations. For the most part, there were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre. There was a risk register specific to the centre that addressed individual and centre related risks. However, a review was needed to the safeguarding risk assessment and the falls risk assessments. This was to ensure that they reflected the current presenting risks and that the measures in place were effective.

The inspector reviewed a sample of residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs. For the most part, there were corresponding support plans in place that guided staff on how to best support residents' assessed needs. The plans were evaluated on a quarterly basis to ensure their effectiveness.

The person in charge and staff were endeavouring to ensure that residents could receive information in a way that they could understand. Residents were provided with communication support plans that had been developed from a comprehensive individual communication assessment.

Overall, appropriate healthcare was made available to residents having regard to their personal plan. Residents' plans were regularly reviewed in line with the residents' assessed needs and required supports. Residents were supported to live healthily and were provided with choice around activities, meals and beverages that promoted healthy living.

Where required, positive behaviour support and psychology plans were provided to residents and were reviewed on a regular basis. All staff had completed training to support them in helping residents to manage their behaviour that challenge.

There was one restrictive practice used in this centre. It was clearly documented and subject to approval and review by the appropriate health professionals. The restrictive practice was supported by appropriate risk assessments which was also reviewed on a regular basis.

Regulation 10: Communication

Communication access and support arrangements were facilitated for residents in accordance with their assessed needs and wishes. The majority of residents living in the centre used verbal communication.

The person in charge was striving to ensure that residents were provided information in a way that they understood. The inspector observed examples of easy-to-read format in residents' personal plan, on residents' notice boards in communal areas and in residents' bedrooms such as 'All about me' plans and large picture formats of residents' planned and achieved goals.

This was to support residents understanding of the information in line with their needs, likes and preferences. For example, the complaints procedure, which was placed on the front hall notice board, was written in easy to read format. In addition, residents were provided with easy-to-read and picture format fire evacuation plan, statement of purpose, residents guide, staff on duty and residents' household chores.

There was a culture of listening to and respecting residents' views in the service. Staff also advocated for residents, and residents were facilitated and supported to access advocates when requested or required. For example, when a resident expressed a preference to move to independent living type of accommodation, one of the measures to respond to their preference, included organising a meeting with an advocate.

Residents' assessment of need included a communication assessment and from this a communication support plan was developed. The support care plan included the method of communication the resident used to express themselves. The information in the support plan provided guidance for staff on how to best communicate with each resident in line with their needs, wishes and preference.

On review of a personal plan for one resident, who communicated non-verbally, the inspector saw that they had been provided a communication passport. The document resembled an easy-to-read 'all about me' document. The inspector found that a review of the content would better enhance the document and may likely provide a more effective tool in supporting communication between staff and the resident.

Judgment: Compliant

Regulation 17: Premises

The provider had failed to complete upgrade works actions to the centre's downstairs shower room and upstairs bathroom in line with the time lines they had committed to on their previous inspection compliance plan.

During inspections of the centre in May 2023 and again in March 2024 , the bathrooms were observed to require upgrades and improvements in order to promote good infection prevention and control arrangements. This issue had also been identified by the provider, through their auditing systems and a schedule of works had been proposed for upgrades to these facilities. On the day of the inspection, the upgrade remained outstanding.

The inspector was informed on the day the provider had applied for a housing adaptation grant to provide funding to complete the works. However, this was at an initial stage. Sections of the form had yet to be completed by a general practitioner before it could be submitted to the necessary department. Overall, the inspector found that the timeliness for the provider to complete the upgrade of these facilities

was not satisfactory and overall, impacting on the safety of residents living in the centre.

In addition, there were a number of other minor remedial works required to the premises to mitigate risks of slips, trips and falls and to ensure the overall aesthetic of the home was kept to the most optimum.

For example:

- There was a door missing from the outdoor mop bucket storage unit which impacted on its effectiveness of storing cleaning equipment in a hygienic location.
- A barbecue (BBQ) located to the rear of the property was in a poor state and the cover, to keep it clean and appropriately stored, was observed on the ground beside it and not utilised for it's required purpose.
- One of the sitting rooms required upkeep and repair to the walls and overall, a review of the décor in the room. There were a number of small holes on one wall which overall, impacted on the effectiveness of cleaning this area and impacted on the aesthetics of the room.
- Some walls needed painting in areas where furniture had been removed and paint had come away.
- In the hallway, the inspector observed two very large hooks sticking out from the wall (previously to hold mobility equipment). These were no longer in use and posed a potential risk of injury while they were in place.

The layout of house was not in line with floor plans or statement of purpose - for example, the upstairs office was now a store room with no facilities to use as an office space. The downstairs staff sleep over room was observed to include a new desk and large storage cabinets and was now also used as a staff office.

While this change in function of the rooms led to an improved office space, filing system and more efficient access to records, it was not reflected in the centre's current statement of purpose (room function section) or floor plans.

Judgment: Not compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents which met the requirements of Regulation 20. For example, on review of the guide, the inspector saw that information in the residents' guide aligned with the requirements of associated regulations, specifically the statement of purpose, residents' rights, communication, visits, admissions and contract for the provision of services, and the complaints procedure.

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

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed the centre's risk management policy and found that the provider had ensured that the policy met the requirements as set out in the regulations. The policy was last reviewed in June 2023 and was due for next review in June 2026.

For the most part, 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.

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.

However, further review of individual and centre safeguarding risk assessments were needed. This was to ensure that they reflected the current compatibility risks in the centre and provided effective measures to manage and reduce the risks.

In addition, a review of the risks and supporting measures in place regarding a resident's risk of falling was needed. There was a falls risk assessment in place for a resident who's physical needs were changing, the assessment had determined the risk as very high and had been colour coded red to reflect the level of risk. The falls risk assessment was completed in January 2025 and last reviewed in October 2025. The provider and person in charge had put a number of risk control measures in place to try manage and reduce the risk of falls.

However, the inspector found that a review of the effectiveness of the measures in place were needed. For example, where a fall occurred some of the measures to mitigate and manage the risk of falls included recording it on the falls tracker, carrying out an investigation and completing an electronic incident form with details of the incident.

Between the months of November and December 2025, the resident's falls tracker recorded six fall incidents however, there had been no further review of the associated risk assessment or measures in place. In addition, the resident was refusing to engage with some of the measures including the use of special footwear and recommended mobility equipment. This added to the risk however, had not been clearly identified on the risk assessment.

The inspector observed some areas where potential slips, trips and falls risks were not being fully mitigated and required improvements.

- There was a large storage shed to the back of the house however, there was no path leading to the door. This meant that there was a potential risk of slip or fall when staff or residents were accessing the shed.
- A watering hose was spread across the path to side of the house, which posed a potential trip risk.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The inspector observed the house to be clean and that cleaning records demonstrated a high level of adherence to cleaning schedules.

There was an up-to-date comprehensive policy relating to infection, prevention and control in the designated centre and it was made available to all staff.

Staff had completed specific training in relation to the prevention and control of infection.

The provider had ensured that an infection prevention and control audit had been completed in 2025. In addition, the monthly data report, included an infection prevention control checklist.

Where there were upkeep and repair works that were impacting on infection prevention and control measures, these have been addressed under, Premises Regulation 17.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of three residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs and that overall, arrangements were in place to meet those needs.

There were support plans for various aspects of each resident's life, including, physical and intimate care supports, general health and rights. This ensured that the supports put in place maximised residents' personal development in accordance to their wishes, individual needs and choices.

The plans were regularly reviewed and residents, and where appropriate their family members, were consulted in the planning and review process of their personal plans. Multidisciplinary reviews were effective and took into account changes in circumstances and new developments in residents' lives.

Residents were provided with accessible formats of their plan. These were in the form of large colourful posters or framed pictures full of photographs and were used in conjunction with each resident's 'all about me' planning meetings.

In addition, residents were provided with a separate poster or framed photographs that included images of them progressing and achieving their goals during 2025.

Judgment: Compliant

Regulation 6: Health care

Overall, the provider and person in charge promoted the rights of residents in relation to making choices around their healthcare and support needs in this area.

The inspector found that appropriate healthcare was made available to residents having regard to their personal plan. Residents' personal plans took into account their physical wellbeing as well as their medical history, mental health, diet and nutritional needs but to mention a few.

Residents were supported to live healthily and were provided with choice around activities, meals and beverages that promoted healthy living. Residents were supported and encouraged to complete exercise programmes recommended by health professionals, go for walks in the outdoors and eat healthily. On observing food in residents' fridges and on review of the weekly menu planner, the inspector saw that there was a lot of fresh healthy food options available to residents.

Residents' healthcare plans demonstrated that each resident had access to allied health professionals including access to their general practitioner (GP). Residents were supported and encourage to attend annual health check-ups or sooner if required. Where residents physical needs were changing the inspector saw that the person in charge had ensured referrals were made to the appropriate health professional and in a timely manner.

During 2025, where a resident became seriously ill, the provider, person in charge and staff team had ensured that the resident was provided appropriate care and support at the end of their life which met their physical, emotional, social and spiritual needs and respected their dignity, autonomy rights and wishes.

The provider had submitted an application to vary the layout of one of the sitting rooms, so that the physical needs, and overall wishes of a resident, near the end of their life could be provided in a dignified and supportive way.

In addition, extra staff hours were added to the roster to ensure appropriate levels of staffing were in place to meet the resident's healthcare, medical and physical needs and in dignified and compassionate manner.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider and person in charge took a positive approach to behaviours that challenge. Where appropriate, residents were provided with a positive behaviour support plan or psychology support plan. The inspectors saw, from a review of two plans, that they were up-to-date and provided satisfactory guidance to staff in supporting residents' manage their behaviour. The plans included appropriate clinical oversight, both in the development and review of the plan. Residents' plans promoted proactive and preventive strategies.

The person in charge ensured that staff had received training in the management of behaviour that is challenging and received regular refresher training in line with best practice. Staff spoken with were knowledgeable of support plans in place and the inspector observed positive communications and interactions throughout the inspection between residents and staff.

There was one restrictive practice implemented in the centre. The restriction in use had been approved by the organisation positive approaches management group. The rationale for restrictions in place were clear and deemed to be least restrictive option.

Judgment: Compliant

Regulation 8: Protection

During 2025 there had been 19 safeguarding notification submitted to the Chief Inspector. The majority of these related to peer to peer safeguarding incidents. The impact of the incidents were resulting in negative outcomes for residents. From gathering residents views through conversations and feedback questionnaires, the inspector noted that two residents had expressed being afraid of their house-mate. Staff also informed the inspector, that they felt there were times residents were "walking on eggshells" when in the company of their house-mate.

One resident told the inspector that there were times when they had felt afraid sometimes. They said there was a lot of shouting in the house and that they got no peace. The resident told the inspector that the shouting occurred at least twice a

week. The resident also relayed that when a peer shouted, they would go to their room. They said they stayed in their own room a lot to avoid interactions with them.

On review of the centre's resident feedback questionnaires, as well as a complaint logged in September 2025, the inspector saw that other residents had also expressed their fear in relation to their house-mate. One questionnaire noted that 'sometimes one of my housemates make me feel afraid. I don't like it, but the staff help me. I go to my room to keep to myself'. It also noted that the resident can be confrontational and can 'come at them', at times. A complaint made by another resident noted that their peer had 'puffed out their chest in an aggressive manner'. The resident noted that they were making the complaint, as they had every right to feel safe in their own home.

The provider and person in charge were striving to implement measures to reduce the risk of ongoing safeguarding incidents occurring in the centre however, further measures were needed to ensure their effectiveness.

For example;

There was no adequate safeguarding plan in place for residents who were being impacted by the compatibly issues in the house. This meant that there was no clear guidance in place for staff on how to manage safeguarding incidents amongst peers.

Where there were interim safeguarding plans in place, three of the plans were due for review in September 2025 however, there was no record of a review completed.

A response to three preliminary screening forms was outstanding since July 2025. A email was sent in November 2025 to ascertain why there was no response. On the day of the inspection, senior management followed up with the organisation's designated officer who confirmed no response had yet been received. The inspector was informed that the designated officer would follow up with the national safeguarding team that day.

There was a risk assessment in place regarding safeguarding vulnerable adults against abuse, however, it was generic and was not reflective of the compatibility issues in the house. As a result there were no specific measures in place for the issue.

There was a safeguarding folder in the centre that included the provider's safeguarding policy so that it was available for staff to read and use when required. The policy was due to be reviewed in September 2025 however, as of the day of inspection, the review had not yet taken place.

A safeguarding support plan, included in a resident's personal plan had been completed in March 2025. However, the plan had not been reviewed since July 2025. The plan was due to be reviewed in quarter three and four of 2025 however, despite there being peer to peer safeguarding incidents, the support plan had not been reviewed. This impacted on the effectiveness of the plan.

Overall, the inspector found that while compatibility issues remained in the centre, the provider could not be assured that residents living in the designated centre were safeguarded at all times.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ardmore OSV-0002353

Inspection ID: MON-0044852

Date of inspection: 07/01/2026

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider gathered all the relavant documents to support the application to the Dublin City Council for the adaptation grant to upgrades the bathrooms in the desginated centre. Application was submitted on the on the 27/01/2026. The provider has added the upgrade to the bathrooms on the work plan for the ended of quarter two.(30.06.2026)	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • The person in Charge completed a review of the complaint with the resident on 21st January 2026. All actions have been recorded in line with our policy and procedure and are available for review within the designated centre. (21/01/2026)	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The provider gathered all the relavant documents to support the application to the Dublin City Council for the adaptation grant to upgrades the bathrooms in the desginated centre. Application was submitted on the on the 27/01/2026. The provided has addedd the upgarde to the bathrooms on the organsation work plan for the ended of quarter two. (30/06/2026) • The head of Technical Service and the Person in Charge completed a walkthrough of the Designated centre, all assessed work will be completed by end of quarter two. (30/06/2026) • The provider will submitted an Application to Vary to reflect the current floor plans in line with the Statement of propose. (07/02/2026) • The Person in charge ordered a new outdoor storeage unit on the 2nd February2026. This will be in palce by 10/02/2026	

• The Barbecue was cleaned and a new BBQ cover was purchased on the 18th January 2026. The cleaning of the BBQ was added to the cleaning rota 31.01.2026 • The person in charge removed the two large hooks from an wall that were no longer in use. – 13/01/2026

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Person in Charge is currently reviewing all safeguarding Risk assessments. Review will be completed by the 28/02/2026.
• Individual co-ordination meeting (ICM) with the multi-disciplinary team (MDT) took place on 10/01/2026 regarding support for the resident who are a high falls risk.
• Relevant risk assessments were reviewed and updated on 10/01/2026.
• Physiotherapist completed an assessment with the resident on 11/01/2026.
• Physiotherapist provided a walker to the resident to use when in the community 11/01/2026.
• Offered a downstairs bedroom to the resident on the 27/01/2026, resident accepted the offer on the 30/01/2026.

• The head of Technical Service and the Person in Charge completed a walkthrough of the Designated centre on the 28/01/2026. Assessed work regarding a path to the shed will be added to the work plan for quarter two. (30/06/2026)

• Watering hose is stored approroptiately in the garden (08/01/2026)

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Person in charge has developed Safeguarding support Plans for all residents; these are complete and in place since 31.01.2026
• Person in charge is currently developing safeguarding risk assessments for each resident on 28/02/2026.
• Review of three interim safeguarding plans were completed, PSF3 are available for review in the designated centre. (21/01/2026)
• The provider has commissioned a Compatibility review for the designated centre on 27/01/2026. The compatibility review will be completed by 31/03/2026.
• The safeguarding policy was in date on the day of inspection; however, the designated centre copy was out of date. Up to date policy has been printed and is available for review. Next review date is February 2027.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2026
Regulation 17(3)	The registered provider shall ensure that where children are accommodated in the designated centre appropriate outdoor recreational areas are provided which have age-appropriate play and recreational facilities.	Not Compliant	Orange	10/02/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre	Substantially Compliant	Yellow	30/06/2026

	to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	28/02/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	21/01/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/03/2026