



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

## Issued by the Chief Inspector

Name of designated centre:	Seanna Cill
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	21 January 2026
Centre ID:	OSV-0002356
Fieldwork ID:	MON-0044900

## About the designated centre

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

Seanna Cill is a designated centre operated by St. Michael's House. The centre is located in Dublin and provides accommodation to a maximum of five male and female adult residents with intellectual and physical disabilities. The service caters for a broad range of needs, including, low to high support needs, behaviour support, medical needs and emotional and environmental needs. The centre comprises of a two storey, six bedroom semi-detached house. It is located close to local amenities such as shops, cafes and recreational facilities in a suburb of Dublin. Each resident has their own bedroom and share communal spaces such as sitting rooms, kitchen and dining areas and bath and shower rooms. Social care staff are on duty both day and night to support residents who live in this centre.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	5
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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 21 January 2026	09:00hrs to 16:40hrs	Kieran McCullagh	Lead

## What residents told us and what inspectors observed

The purpose of this unannounced inspection was to monitor the care and welfare, and support arrangements for residents living in the centre and assess compliance with the regulations. This inspection determined that although residents were provided with quality care and support, improvements were identified under a number of regulations inspected. Specifically, enhancements were necessary pertaining to staffing, and personal possessions. Additionally, improvements were required in relation to training and staff development, governance and management, and food and nutrition.

To form judgements on the residents' quality of life, the inspector used observations, interactions and conversations with the residents, a thorough review of documentation, and conversations with key staff. The inspector did not have an opportunity to speak with the relatives of any of the residents, however a review of the provider's annual review of the quality and safety of care evidenced that they were happy with the care and support that their relatives received.

The designated centre comprised of one two-storey building, located in a northside suburb of Dublin. The house comprised of six bedrooms, including a staff sleepover room, a staff office, a kitchen / dining room, a sitting room, a quiet room, a utility room, and two large bathrooms. The centre is registered to accommodate five people and the inspector had the opportunity to meet and talk to four residents over the course of the inspection. One resident advised they did not wish to meet or talk to the inspector, and their wishes were respected.

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 capable person in charge, supported by a staff team, who was knowledgeable about the support needs of the residents living in the centre. The person in charge worked full-time and were supported in their role by a service manager, who in turn reported to a Director of Adult Services.

The inspector carried out a walk around of the centre in the presence of the person in charge. The premises was observed to be clean and tidy and was decorated with residents' personal items such as photographs and artwork. Residents' bedrooms were laid out in a way that was personal to them and included items that was of interest to them.

Residents met and spoken with told the inspector they liked living in their home, and that they felt safe and were happy. One resident showed the inspector their bedroom, which was decorated with posters of their favourite soccer team. They spoke to the inspector about their interests, which included gaming. They told the inspector they were very happy and had no complaints. The resident spoke about upcoming birthday plans and a party they had planned. They showed the inspector

new clothes they had purchased supported by their keyworker. The resident also shared positive interactions and jokes with the person in charge, and it was apparent to the inspector they had built up a strong and trusting rapport.

Another resident also showed the inspector their bedroom, which had been personalised to their specific tastes and interests. They showed the inspector their collection of cuddly toys, and told the inspector they were happy and felt safe.

The inspector also briefly met with two other residents when they had returned from their respective activities. One resident had spent the day in their day service programme and appeared happy and content on their return. They warmly greeted the inspector, and the inspector observed positive and respectful interactions between the resident and the staff team that was supporting them. Another resident had been supported to engage in community activities as per their will and preference. They were relaxing in the kitchen and spoke to the inspector about shopping they had done. They were content and happy, and told the inspector they were very happy living in their home.

One resident chose to spend their day in the quiet room of the designated centre for the duration of the inspection. The inspector did not have the opportunity to speak with the resident. However, they observed the resident to be relaxed and happy throughout the duration of the inspection. The inspector observed and heard staff interact and communicate with the resident regularly, and it was apparent that the resident felt at ease and comfortable in the presence of staff, and in their home.

Throughout this inspection, residents appeared comfortable and at ease with staff, demonstrating a relaxed and happy demeanor in their home. It was evident that they had a strong rapport with the staff. The centre itself presented as a calm, relaxed environment, free from any sense of restriction.

The person in charge spoke about the high standard of care all residents received. They also spoke about some of the changing needs of residents and some of the challenges they faced. For instance, one resident had recently started to struggle with the transition from home to their day service programme, and was sometimes refusing to go. A review of this resident's personal care support plans also evidenced that the resident was unable to access the community independently and required staff support to avail of public transport. Another resident who had positive behavioural support needs also required staff support to access the community and did not like to avail of public transport. Due to a lack of a dedicated vehicle, some residents were required to pay for private taxis to attend appointments and community activities of their choosing.

On the day of this inspection a staff team meeting had been scheduled and the inspector took the opportunity to sit in for a portion of this meeting. All staff who attended were professional, and were very knowledgeable of the residents likes, preferences, and assessed needs. They all spoke kindly and respectfully about the residents and gave a detailed update on residents' appointments, changing needs, and goal updates.

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.

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 centre was managed by a full-time person in charge who met the requirements of Regulation 14.

The staffing arrangements required refinement to strengthen the overall structure, and ensure consistent, high-quality care for all residents. During this inspection, the inspector noted a significant dependency on relief and agency staff to cover vacant shifts, as confirmed by a detailed review of staff rosters. This heavy reliance on temporary personnel compromised the continuity of care for the residents. Furthermore, improvements were also necessary to the recording of agency and relief staff used to back fill vacant shifts.

Appropriate training is fundamental in supporting staff to effectively and appropriately support all residents. The provider and person in charge had not ensured that all staff had up-to-date mandatory training in critical areas such as positive behavioural supports. Furthermore, some staff had not completed service specific training to enable them to provide safe and appropriate care to residents. A supervision schedule and supervision records of all staff were maintained in the designated centre. The inspector saw that staff were in receipt of regular, quality supervision, which covered topics relevant to service provision and professional development.

The provider ensured that the directory of residents was readily available in the centre, in full compliance with regulatory requirements. It contained accurate and up-to-date information for each resident.

Improvements were required to ensure the provider had suitable oversight of the centre and that effective governance arrangements were in place to ensure the service was safely and effectively managed. Specifically, improvements were necessary to ensure the designated centre was appropriately resourced to meet the assessed and known needs of all residents living in the home. Furthermore,

enhancements were required to a number of local auditing systems to ensure up-to-date, and accurate information was being recorded.

There was an effective complaints procedure in place that was accessible and in a format that residents could understand. Residents were supported through the complaints process, which included having access to an advocate when making a complaint or raising a concern. The inspector found that there was a culture of openness and transparency that welcomed feedback, the raising of concerns and the making of suggestions and complaints.

The following section of this report will focus on how the management systems in place are contributing to the overall quality and safety of the service provided within this designated centre.

## Regulation 14: Persons in charge

The designated centre was managed by a full-time person in charge. They were also responsible for another designated centre operated by the provider. The inspector found that the person in charge had the required knowledge, skills, and experience to meet the requirements for this regulation.

The person in charge was actively implementing the provider's systems to ensure oversight and monitoring in this centre. They were developing action plans and implementing the required actions to bring about improvements in relation to the residents' home, and their care and support.

It was evident from the person in charge's interactions with residents on the day of the inspection that they knew them very well. Through discussions and a review of documentation, the inspector found that the person in charge was motivated to ensure that each resident was in receipt of a good quality and safe service.

Judgment: Compliant

## Regulation 15: Staffing

Overall, improvements were required to the staffing arrangements, and oversight of staff rosters to ensure continuity of care for all residents residing in the designated centre.

At the time of this inspection there were 3.5 whole time equivalent (WTE) positions vacant. The inspector completed a thorough review of staff rosters for the months of November 2025, December 2025, and January 2026. Although the provider was endeavouring to back fill vacant shifts, it was found that there was an over reliance

on relief and agency staff to cover vacant shifts. For instance, the inspector found that:

- 37 shifts were covered by six different relief staff across the month of November 2025. A further four shifts were covered by two different agency staff
- 48 shifts were covered by 12 different relief staff across the month of December 2025
- 46 shifts were covered or planned to be covered by 13 different relief and agency staff across the month of January 2026.

The provider had not ensured that suitable contingency arrangements were in place to ensure continuity of care for residents.

The inspector also observed that improvements were needed regarding staff rosters. Specifically, the full names of relief and agency staff was not consistently recorded, and in some instances, the agency's name was missing. This area required improvement by the person in charge to ensure accurate and complete documentation.

Judgment: Not compliant

## Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents. A review of the most recent training records made available to the inspector evidenced gaps in relation to both mandatory and non-mandatory training for staff. For instance, the inspector observed the following:

- Four staff required online training in fire safety
- Two staff required refresher training in positive behavioural supports
- One staff required safe administration of medication training
- Four staff required refresher training in emergency first aid
- None of the staff team had training in managing Phenylketonuria (PKU).

The deficits in staff training posed a risk to the quality and safety of the care and support provided to residents and their wellbeing, and required review and consideration by the provider and person in charge.

Staff members were in receipt of quarterly supervision, as per the provider's policy. The person in charge had developed a schedule of supervision for 2025 for all staff members. The inspector reviewed this and found that all staff were in receipt of regular formal supervision and informal support relevant to their roles from the person in charge. The inspector reviewed two staff members supervision records, all

of which included a review of the staff members' personal development and provided an opportunity for them to raise any concerns.

Judgment: Substantially compliant

### Regulation 19: Directory of residents

In compliance with regulations, the provider ensured an accurate and up-to-date resident directory was maintained.

The inspector confirmed that all information met the required standards as set out in Schedule 3 and that effective systems were implemented to ensure ongoing accuracy. For example, the directory of residents included the name, address, date of birth, sex, and marital status of each resident, the name, address and telephone number of each resident's next of kin or representative and the name, address and telephone number of each resident's general practitioner (GP).

Judgment: Compliant

### Regulation 23: Governance and management

Improvements were required to ensure the provider had suitable oversight of the centre and that effective governance arrangements were in place to ensure the service was safely and effectively managed.

The designated centre was not appropriately resourced to ensure the effective delivery of care and support to all residents. As previously reported, the provider did not have effective contingency plans to ensure continuity of care for all residents, and there was an over reliance of the use of relief staff to back fill vacant shifts. In addition, the designated centre did not have a dedicated vehicle to transport residents to appointments or activities. Some residents were unable to travel independently and required additional staff supports, while other residents had assessed positive behavioural support needs and were unable to travel independently. Lack of appropriate transport meant that some residents were refusing to attend day service programmes or were required to pay for private taxis to transport them to their preferred activities. This required review and consideration by the provider.

The provider and local management team carried out a suite of audits, including audits on fire safety, premises, and health and safety. However, improvements were required to a number of local audits completed. Specifically, enhancements to infection prevention and control (IPC), and residents' finance audits were necessary to ensure the provider and person in charge fully recognised the importance of

quality audits in shaping an effective quality improvement strategy and that service delivery remained safe and effective.

An annual review of the quality and safety of care had been completed for 2024. It evidenced that the annual review assessed the centre against relevant national standards while also containing important feedback from and consultation with residents and their representatives. In addition, the inspector reviewed the action plan created following the provider's most recent six-monthly unannounced visit, which was carried out in December 2025. Following review of the action plan, it was observed that the majority of actions had been completed, and were being used to drive continuous service improvement.

Judgment: Substantially compliant

### Regulation 34: Complaints procedure

The provider had implemented an effective complaints procedure for residents, which was underpinned by a complaints policy. The policy outlined the processes for managing complaints including the stages of resolution, the associated roles and responsibilities, the appeals process, and how residents could access advocacy services.

The procedure had been prepared in an easy-to-read format for residents and their representatives, which also included an easy-to-read complaints poster and complaints form. There were no recent or open complaints on file on the day of this inspection.

Residents spoken with told the inspector that they were happy, and had no complaints. The provider's complaints and incident manager had recently completed a complaints audit, which was also reviewed by the inspector. The audit found that there were appropriate procedures in place for dealing with and managing complaints, and that all residents had knowledge of how to raise concerns, and how to make a complaint.

Judgment: Compliant

### Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre. Overall, the inspector found that the provider was endeavouring to support residents in a person-centred manner. However, improvements were required to ensure that all residents' finances were

effectively audited, and managed in line with the provider's policy, and that residents had appropriate nutritional support plans in place in line with their assessed needs.

Staff knew each residents' communication requirements and the inspector observed throughout the inspection that staff were flexible and adaptable with all communication strategies used. There was a culture of listening to and respecting residents' views in the service and residents were facilitated and supported to communicate with their families and friends in a way that suited them. Staff were in receipt of total communication training which supported and informed their communication practice and interactions with residents living in this centre and as observed by the inspector during the course of the inspection.

Improvements were required to ensure effective oversight, recording, and auditing of all residents' finances. Specifically, enhancements pertaining to residents' maintained expenditure records was required. The inspector identified a number of discrepancies and inaccuracies within residents' finance records which required review. Additionally, a comprehensive review and update of the provider's policy in the management of residents' monies and possessions was also necessary.

The inspector found the atmosphere in the designated centre to be warm and relaxed, and residents told the inspector they were very happy living in their home, and with the support they received. The inspector completed a walk around of the centre and found the design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable and homely environment. There was adequate private and communal spaces and residents had their own bedrooms, which were decorated in line with their personal taste and preferences.

Enhancements were needed to ensure that residents with identified nutritional care requirements had current and accurate nutritional care plans on record. For instance, one resident with a formal diagnosis of phenylketonuria (PKU) did not have a formal nutritional care plan on file. In addition, staff were not in receipt of specialist training to support the resident to manage their condition.

The inspector found evidence that the provider was ensuring the delivery of safe care while balancing the right of residents to take appropriate risks to maintain their autonomy and fulfill the provider's requirement to be responsive to risk. The organisation's risk management policy met the requirements as set out in Regulation 26. There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre.

The person in charge had ensured that residents' health, personal and social care needs had been assessed. The assessments reflected the relevant multidisciplinary team input, and informed the development of care plans, which outlined the associated supports and interventions residents required.

## Regulation 10: Communication

The provider demonstrated respect for core human rights principles by ensuring that residents could communicate freely and were appropriately assisted and supported to do so in line with their assessed needs and wishes.

The inspector found there was an individual approach to supporting residents that recognised the uniqueness of each resident's communication skills and abilities. For example, where residents presented with limited verbal communication, staff used a total communication approach, which included gesture in conjunction with simple consistent phrases, Lámh, and non-verbal cues.

The inspector reviewed two residents' communication support plans and communication passports, and found that information recorded within them was accurate and up-to-date. Communication support plans were detailed, comprehensive and developed by an appropriately qualified person.

Overall, the inspector found that residents were cared for by staff who understood their communication needs and could respond accordingly. Residents had access to information that was appropriate to their communication needs. For example, the inspector observed easy-to-read information relating to safeguarding, and the complaints process displayed on notice boards throughout the designated centre.

Judgment: Compliant

## Regulation 12: Personal possessions

Improvements were required to ensure effective oversight, recording, and auditing of all residents' finances.

The provider had an established policy for the management of residents' monies and possessions. The inspector reviewed this policy and found that it had not been reviewed in accordance with regulatory requirements. The policy in place set out the responsibilities for the person in charge, and assigned staff members as well as very clear protocols for staff to follow pertaining to recording, and auditing of residents' finances. The inspector found that the person in charge, and staff members were not adhering to protocols set out in the provider's policy. For instance, adequate systems and controls were not in place in respect of the safety of residents' finances.

The inspector completed a thorough review of two residents' expenditure records over the course of 2025. For example, the inspector reviewed one resident's expenditure records from January 2025 to March 2025, and one resident's expenditure records from October 2025 to December 2025. During this process, the inspector noted a number of discrepancies and inaccuracies throughout the reviewed periods. Specifically, a number of transactions lacked valid receipts, and a

number of bank withdrawals were not properly documented with their corresponding purposes.

Furthermore, enhancements were required to the auditing of all residents' finances. For example, the inspector noted that monthly audits were not accurately documenting or recording discrepancies, or missing receipts. This necessitated detailed follow-up and careful consideration by both the provider and the person in charge.

Judgment: Not compliant

## Regulation 17: Premises

The registered provider ensured that the designated centre was designed and arranged to align with the service's aims and objectives, as well as the number and needs of residents. The centre was well-maintained, clean, and appropriately decorated.

The inspector observed a warm and calm atmosphere within the designated centre. Residents spoken with expressed high levels of satisfaction with their living environment and the support they received. The living environment was stimulating and provided opportunities for rest and recreation. Each resident participated in choosing equipment and furniture in order to make it their home. For example, all were involved in choosing equipment and furniture for their bedroom in order to make it personal and individual to them.

Residents had their own bedrooms, each considerably decorated to reflect their individual style and preferences. For example, rooms were personalised with family photographs, artworks, soft furnishings and possessions, all in line with each residents' interests. This not only promoted their independence and dignity but also celebrated their uniqueness and personal taste. Additionally, each bedroom was equipped with ample and secure storage for personal belongings.

Residents had access to facilities which were maintained in good working order. There was adequate private and communal space for them as well as suitable storage facilities and the centre was found to be clean, comfortable, homely and overall in good structural and decorative condition.

The equipment used by residents was both easily accessible and stored securely. Records reviewed by the inspector evidenced that the equipment was regularly serviced, with items such as high-low beds undergoing annual servicing.

Judgment: Compliant

## Regulation 18: Food and nutrition

Improvements were required to ensure that residents with assessed nutritional care needs had up-to-date nutritional care plans on file.

One resident was living with phenylketonuria (PKU). The inspector noted that the resident attended regular blood test appointments as per their care support plan. However, it was also noted that the resident's last dietetic review was completed in May 2020. There was no associated nutritional care plan on file to guide or support staff in the management of PKU. This raised concerns in relation to the management of the resident's nutritional care needs and specialised diet. In addition, as previously noted under Regulation 16: Training and staff development, none of the staff team had specific training in managing PKU. This required considerable review by the person in charge.

Residents living in this designated centre did not have an assessed need in the area of feeding, eating, drinking and swallowing (FEDS). Residents were consulted with and encouraged to lead on menu planning and had the opportunity to participate in the preparation, cooking and serving of their meals as they so wished. For instance, one resident was observed preparing their packed lunch for the following day.

The inspector noted a varied range of food and drinks, including fresh and perishable items, stored in the kitchen for residents to select from. All items were stored in a hygienic manner. The kitchen was well-equipped with high-quality cooking appliances and utensils, providing residents with everything needed to prepare their own meals, if they so wished.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

The provider had an established integrated risk management policy in place, and was next due review in June 2026. The policy was reviewed by the inspector which evidenced that the provider had ensured the policy included all necessary information in accordance with regulatory requirements. For instance, it contained detailed information on managing the unexpected absence of a resident, accidental injuries, self-harm, and outlined the systems in place within the designated centre for the assessment, management, and ongoing review of risk.

In line with the risk management policy, there was a risk register in place which detailed potential risks in the centre as well as the measures in place to reduce or eliminate them.

On the day of this inspection, the inspector found that each residents' safety, health and wellbeing was supported through individual risk assessment forms. Risk

assessment forms included appropriate measures and actions in an attempt to control and mitigate identified risks. For example, where risks had been identified for a resident pertaining to behaviours that challenge, an up-to-date and appropriate positive behaviour support plan was in place.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

The inspector reviewed five residents' files and saw that files contained up-to-date and comprehensive assessments of need. These assessments of need were informed by the residents, their representative and the multidisciplinary team as appropriate.

The assessments of need informed comprehensive care plans which were written in a person-centred manner and detailed residents' preferences and needs with regard to their care and support. For example, the inspector observed plans on file relating to the following:

- Communication
- Positive behaviour support
- Rights
- General health
- Physical and intimate care.

Each resident was assigned a keyworker and they supported the resident to engage with and participate in decisions about their own lives and the running of their home. For instance, residents participated in individual keyworking meetings in which they discussed weekly activities, daily activity choices, and meals.

All residents participated in "My Life Meetings" throughout 2025. During these meetings, residents set meaningful goals they aimed to achieve. Examples of 2025 goals set included going to a wrestling show, going out for fish and chips, cinema outing, meal out in the community, and boat trip. The provider had in place systems to track goal progress. For instance, goals were discussed with residents during keyworking and recorded in goal progress documentation. In addition, photographs of the resident participating in their chosen goals and how they celebrated were also included in their personal plan.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant

# Compliance Plan for Seanna Cill OSV-0002356

Inspection ID: MON-0044900

Date of inspection: 21/01/2026

## 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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: <ul style="list-style-type: none"> <li>• One full-time Social Care Worker recruited and commenced on the roster on 19/01/26</li> <li>• A recruitment campaign is ongoing to fill the remaining posts.</li> <li>• Where agency and relief staff are used, the name of the agency and full name of staff will be documented consistently. The person in charge will complete monthly audits of rosters to ensure compliance with documentation requirements. Worked rosters will be sent to the Service Manager for review.</li> <li>• The providers relief co-ordinator has been contacted &amp; a request has been placed to block book two relief staff; this will support the continuity of care in the designated centre.</li> </ul>	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: <ul style="list-style-type: none"> <li>• A referral has been sent to The Director of Nursing and the metabolic clinic requesting staff training for PKU – 22/01/2026</li> <li>• Four staff have completed fire safety training – 05/02/2026</li> <li>• Two staff who required refresher training in positive behavioural supports have commenced there 2-day training as of 04/02/26 &amp; are scheduled for day 2 on the 25/02/26</li> <li>• One staff completed safe administration of medication training same on the 10/02/2026</li> <li>• Four staff who required refresher training in emergency first aid have been booked. All staff will have completed this training by the 24/02/2026</li> </ul>	
Regulation 23: Governance and management	Substantially Compliant

<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> <li>• One full-time Social Care Worker recruited and commenced on the roster on 19/01/26</li> <li>• A recruitment campaign is ongoing to fill the remaining posts.</li> <li>• Where agency and relief staff are used, the name of the agency and full name of staff will be documented consistently. The person in charge will complete monthly audits of rosters to ensure compliance with documentation requirements. Worked rosters will be sent to the Service Manager for review – 05/02/2026</li> <li>• The providers relief co-ordinator has been contacted &amp; a request has been placed to block book two relief staff; this will support the continuity of care in the designated centre.</li> <li>• Residents transport arrangements will be reviewed and considered in line with Organisational policies and procedures and Residents contracts of care. 28/02/2026</li> <li>• The Service Manager and Person in Charge have reviewed and amended the IPC audit to ensure all issues are captured and escalated as required – 05/02/2026</li> <li>• The Service Users money and personal possessions policy is currently being reviewed and will be available for dissemination 20/03/2026  </li> </ul>	
Regulation 12: Personal possessions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 12: Personal possessions:</p> <ul style="list-style-type: none"> <li>• The Service Users money and personal possessions policy is currently being reviewed and will be available for dissemination 20/03/2026</li> <li>• An internal audit of residents' finances will be completed by the Finance Department to provide independent oversight of financial management practices within the designated centre. Findings from the audit will be documented, shared with the provider and person in Charge – 28/02/2026</li> <li>• Monthly Audits will be completed by the Person in Charge and available for review in the Designated Centre.</li> <li>• 6 Monthly Audits will be completed by the Service Manager and will be available for review in the Designated Centre.  </li> </ul>	
Regulation 18: Food and nutrition	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 18: Food and nutrition:</p> <ul style="list-style-type: none"> <li>• A referral has been sent to The Director of Nursing and the metabolic clinic requesting staff training for PKU – 22/01/2026</li> <li>• A referral has been submitted and received by the providers Dietetics team – 29/01/2026</li> <li>• A nutrition plan for PKU is in place and available for review in the Designated Centre.  </li> </ul>	

## 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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	20/03/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/05/2026
Regulation 15(3)	The registered provider shall	Not Compliant	Orange	30/05/2026

	ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	04/02/2026
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	24/02/2026
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Substantially Compliant	Yellow	29/01/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre	Substantially Compliant	Yellow	30/05/2026

	is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	20/03/2026