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:	Sabhaile
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	16 September 2025
Centre ID:	OSV-0002370
Fieldwork ID:	MON-0039499

About the designated centre

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

Sabhaile is a residential service operated by St Michael's House. It provides care and support for up to five adults with an intellectual disability. The centre comprises one large single-storey house located in a North Dublin suburb, with five bedrooms, a kitchen and dining room, large living area and second small living room, utility room and staff room. Sabhaile has a modest-sized contained garden and is located in close proximity to a range of local amenities. Residents are supported by a team of nurses and social care workers who are managed by a person in charge. Residents receive support in areas such as personal development, healthcare and independent living support.

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
Tuesday 16 September 2025	09:20hrs to 17:45hrs	Kieran McCullagh	Lead
Tuesday 16 September 2025	09:20hrs to 17:45hrs	Sarah Barry	Support

What residents told us and what inspectors observed

This report outlines the findings of an announced inspection of the designated centre, Sabhaile. The inspection was carried out to assess compliance with the regulations following the provider's application to renew the centre's registration. This inspection determined that although residents were provided with quality care and support, and were safeguarded from abuse, improvements were identified under a number of regulations inspected. Specifically, enhancements were necessary pertaining to staffing, notification of incidents, communication, and premises.

To form judgements on the residents' quality of life, inspectors used observations, interactions with the residents in this service, a thorough review of documentation, and conversations with key staff. Inspectors 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 centre was registered to accommodate five adult residents. Upon arriving to the centre, inspectors were greeted by the person in charge. At that time, one resident had already departed for their day service, while two others were awaiting transportation. The remaining two residents were enjoying a leisurely lie-in. Throughout the morning, inspectors had the chance to briefly engage with all five residents, in accordance with their preferences. Throughout the day, residents were observed coming and going; one shared plans to go bowling, while another looked forward to a trip to the cinema.

Residents in the centre presented with a variety of communication support needs and were supported by staff to communicate and interact with inspectors throughout the inspection as required. Residents indicated that they were very happy with the service and it was apparent to inspectors that they liked the staff and felt comfortable in their presence. On observing residents interacting and engaging with staff, it was obvious that staff could interpret what was being communicated to them by the residents.

Warm interactions between the residents and staff members caring for them was observed throughout the duration of the inspection. On the day of the inspection inspectors observed residents to be relaxed and comfortable in the centre, staff engaged with them in a very kind and friendly manner, and it was clear that they had a good rapport.

The designated centre is a purpose built bungalow situated beside one of the provider's adult day service centres. The centre comprised of five single occupancy bedrooms, a staff office / sleepover room, a kitchen, a sitting room, a living room, a utility room, a bathroom, and a large accessible shower room. Residents' bedrooms were arranged in a way that reflected their personal preferences, featuring items of

interest to them. Inspectors observed that residents had unrestricted access to both indoor spaces and the garden.

During their visit, inspectors noted that additional cleaning was required in the centre. For example, skirting boards throughout the designated centre were visibly dirty and required deep cleaning. Furthermore, inspectors identified a number of maintenance issues that needed the provider's attention. For instance, visible damage to walls, including residents' bedrooms walls was observed by inspectors during the walk through of the centre. Damage to residents' bedroom door architraves and bathroom doors, and sofas used by residents in the sitting room was also observed. It was noted by inspectors that both the residents' bedrooms and the communal areas within the designated centre would benefit from repainting, thereby enhancing the cozy atmosphere and improving the overall aesthetics.

In advance of the inspection, residents had been sent Health Information and Quality Authority (HIQA) surveys. These surveys sought information and feedback about what it was like to live in this designated centre. Completed surveys were reviewed by one inspector following the inspection. The feedback in general was very positive, and indicated satisfaction with the service provided to them in the centre, including activities, food and choices and decisions. However, some residents did comment that would like to know all of the staff better, while another resident reported that they would like changes made to their bedroom to better meet their needs.

Inspectors noted that the design and layout of one resident's bedroom did not adequately accommodate their assessed needs. The resident faced mobility challenges and required the use of assistive equipment, such a wheelchair and a sit-to-stand hoist, throughout the day. However, the bedroom offered limited space for storing this equipment. During a recent fire drill, it was also documented that the width of the bedroom door was insufficient for a swift and safe exit. While no immediate fire safety issues were identified, inspectors highlighted that future concerns could arise if the situation remained unaddressed. On the day of inspection, the provider had no clear strategy or solution in place to address these concerns.

The person in charge emphasised the high standard of care provided to all residents and expressed no concerns regarding their wellbeing or safety. However, they did highlight issues related to the amount of nominated drivers within the staff team. The centre was equipped with its own dedicated vehicle for transporting residents to various activities and outings. However, the person in charge was the sole staff member authorised to operate the vehicle. Consequently, when they were off duty, residents had to rely on alternative transportation methods, such as public transport or private taxis. Concerns were raised about the upcoming winter months and colder weather, and these issues were escalated to the service manager. However, at the time of inspection, no definitive solution or timeline had been established to resolve these concerns.

Inspectors also spoke with four staff members on duty on the day of inspection. They all spoke about the residents warmly and respectfully, and demonstrated a rich

understanding of the residents' assessed needs and personalities, and a commitment to ensuring a safe service for them. It was evident that the staff team were familiar with the needs of the residents. For example, staff members were familiar with each resident's dietary preferences and preferred activities. Residents were observed to be at ease among the staff members and enjoyed their company.

From interacting with residents and observing them with staff, it was evident that they felt very much at home in the centre, and were able to live their lives and pursue their interests as they chose.

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 presents the inspection findings regarding the leadership and management of the service, and evaluates how effectively it ensured the provision of a high-quality and safe service.

The staffing arrangements required improvement to enhance both the skill-set and the overall structure of staffing within the designated centre, to ensure consistent, high quality care for all residents. For instance, inspectors observed a heavy reliance on agency and relief staff to fill vacant shifts, as evidenced by a thorough review of staff rosters.

Inspectors were informed that when agency staff were on shift a permanent staff member was also rostered on shift. This arrangement was in place to ensure that permanent staff had the required and necessary training and skill-set to respond to residents' assessed needs. For example, permanent staff had the required skills in communicating with residents. The staff team had previously raised concerns about the high usage of agency staff, and inspectors noted that the high frequency use of agency and relief staff was contributing to a very heavy work load on a small permanent staff team.

Furthermore, improvements were needed in the staff's skill-set. During the inspection and as evidenced in documented audits, it was noted that there was a reliance on a single staff member to operate the designated centre's dedicated vehicle. While this did not currently negatively affect resident activities, it raised concerns about the upcoming winter months and colder weather. In such conditions, residents would likely need to rely on public transport or alternative means, such as private taxis, for appointments and activities. This situation called for a comprehensive review by the provider.

All staff members were in receipt of both mandatory and supplementary training to ensure the highest standard of care for residents. This was confirmed through a review of the staff training matrix and direct discussions with staff on duty. Every team member, including agency personnel, demonstrated a comprehensive understanding of their training.

The person in charge was supported in their role by a service manager, however, during the inspection, it was revealed that the service manager was on extended leave. Consequently, the person in charge did not receive the regular formal supervision typically required for their role, and they were not fully supported in fulfilling their regulatory responsibilities. It was recommended that alternative support structures were put in place to ensure that the person in charge received adequate supervision and support.

Some improvements were required in relation to the governance and management systems in this designated centre. Required three day notifications had not been submitted to the Chief Inspector of Social Services, in line with regulatory requirements. Inspectors also noted the need for improvements in the ongoing auditing and monitoring of the designated centre to ensure that an effective quality assurance system was in place.

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

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted a complete application to the Chief Inspector of Social Services, requesting the renewal of the designated centre's registration.

The inspector reviewed the application prior to this inspection. All required information and documentation specified in Schedule 2 and Schedule 3 were included in the application.

Additionally, the provider ensured that the fee for renewing the registration of the designated centre, as outlined in Section 48 of the Health Act 2007 (as amended), was paid in full.

Judgment: Compliant

Regulation 15: Staffing

On the day of the inspection the provider had ensured there was enough staff with the right qualifications and experience to meet the assessed needs of residents.

However, improvements were required to the staffing skill-set, and arrangements to ensure continuity of care for all residents residing in the designated centre.

There were 2.5 Whole Time Equivalent (WTE) positions vacant in the designated centre. Although the provider was endeavouring to back fill vacant shifts, it was found that there was an over reliance on agency and relief staff to cover vacant shifts, which was having a negative impact on both residents and permanent staff members.

For example, following a review of the planned and actual rosters maintained in the designated centre for the months of July, August, and September 2025,

- 44 shifts were covered by a total of 16 different agency staff across the month of July 2025.
- 18 different agency staff covered a total of 45 shifts across the month of August 2025.
- 12 different agency staff had covered or were rostered to cover a total of 36 shifts across the month of September 2025.
- A further 32 shifts had also been covered by three different relief staff over that three month period.

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

Improvements were also required to the recording of agency and relief staff used to back fill vacant shifts. For example, agency and relief staff were not documented on the designated centre's planned or actual rosters. Instead, they were recorded on a separate "Relief - Agency Call Out Sheet". This proved difficult to read as all names were handwritten, and the inspector observed that there were numerous occasions in which the full name of the agency staff was not recorded. This required enhancement to ensure the provider and person in charge had easy access to accurate and up-to-date staff rosters.

Inspectors carried out a comprehensive review of the provider's 2024 annual report, as well as the biannual unannounced visit reports. In these provider-led audits and reviews inspectors noted issues had been raised about the operation of the centre's dedicated vehicle which was a large wheelchair accessible minibus.

Inspectors sought clarification from the person in charge, who confirmed that they were the sole staff member responsible for driving the bus. Consequently, when they were off-duty, residents had to rely on alternative transportation for their planned activities.

Although the person in charge has escalated this issue to their line manager previously, there was no clear plan or immediate solution in place to address the highlighted concerns.

Judgment: Not compliant

Regulation 16: Training and staff development

Effective systems for recording and monitoring staff training were implemented, ensuring staff were well-equipped to provide quality care. However, improvements were required to ensure all staff were in receipt of quality supervision in accordance with the provider's policy.

A review of the staff training records evidenced all staff members had completed a diverse range of training courses, enhancing their ability to best support the residents.

This included mandatory training in fire safety, positive behavioural supports, and safeguarding, which contributed to a safe and supportive environment for the residents living in this service.

In addition and to enhance quality of care provided to residents, further training was completed, covering essential areas such as safe administration of medication, manual handling, wheelchair clamping, oxygen therapy, emergency first aid, feeding, eating, drinking, and swallowing (FEDS), and infection prevention control (IPC).

Supervision meetings between staff and their line managers was not occurring in the centre in line with the provider’s own established supervision policy.

Through documentation review and conversations with the person in charge it was evidenced that the last record of a supervision meeting between the person in charge and their line manager took place in October 2024. The person in charge also informed inspectors that they had not had a supervision meeting this calendar year.

In addition, not all staff in the designated centre had had a supervision meeting each quarter of 2025. For example, one inspector reviewed the supervision records for three staff members. Of these three staff members, one had not received a supervision meeting in quarter two and one staff member had not had a supervision meeting in quarter one.

Regular supervision is vital for ensuring that staff receive the guidance, feedback, and communication they need to excel in their roles. Therefore, a review of supervision arrangements was required in order to address identified gaps during this inspection.

Judgment: Substantially compliant

Regulation 22: Insurance

The service was sufficiently insured to cover accidents or incidents. The necessary insurance documentation was submitted as part of the application to renew the centre's registration.

Upon review, it was confirmed that the insurance policy covered the building, their contents, and residents' personal property.

Additionally, the insurance also provided coverage for risks within the centre, including potential injury to residents.

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 person in charge was responsible for the management of this designated centre only. They were suitably qualified and experienced, and had a comprehensive understanding of the service needs. However, they were not supernumerary to the roster and were only allocated five days, referred to as 'management days', per month. This inspection highlighted that the person in charge did not have effective structures in place to support them in meeting their regulatory responsibilities. This required consideration and review by the provider.

An annual review of the quality and safety of care had been completed for 2024. A copy of this report was submitted by the provider prior to the inspection and was reviewed by one inspector. 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, one inspector reviewed the action plan created following the provider's most recent six-monthly unannounced visit, which was carried out in June 2025. Following review of the action plan, it was observed that three of the six actions identified had been completed. However, actions pertaining to staffing and maintenance of the designated centre remained open with no clear time frame for completion in place.

The provider and local management team carried out a suite of audits, including audits on fire safety, health and safety, infection prevention control (IPC), medicine, and restrictive practices. However, inspectors noted that some improvements were required. For instance, audits had failed to identify some restrictive practices that

were in use within the designated centre or issues pertaining to the safe storage of residents' medicines.

This required review 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.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

As part of the application to renew the registration of the designated centre, the provider submitted a statement of purpose that clearly described the services offered and met the regulatory requirements.

One inspector reviewed the statement of purpose and found that it clearly outlined the care model and the support provided to residents, as well as the day-to-day operations of the designated centre.

Additionally, a walk-around of the designated centre confirmed that the statement of purpose accurately reflected the available facilities, including room sizes and their intended functions. Inspectors observed that a copy of the statement of purpose was available to residents located in the entrance hallway of the designated centre.

Judgment: Compliant

Regulation 31: Notification of incidents

Inspectors found that improvements were required so that there were effective information governance arrangements in place to ensure the designated centre complied with notification requirements at all times.

During the inspection inspectors were informed of and observed documented evidence of two incidents pertaining to allegations of misconduct which had occurred in November 2024 and June 2025. Although the provider had taken appropriate actions to mitigate the risk of recurrence, the person in charge had not ensured that these were notified to the Chief Inspector in line with Regulation 31(1)(e).

Furthermore, it was identified through observations and conversations with key staff that other required notifications to the Chief Inspector were not submitted as mandated. Specifically, failure to report incidents involving the use of restrictive

procedures as required by Regulation 31(3)(a), for example, financial restrictions and night checks of residents

Inspectors requested that these were notified to the Chief Inspector retrospectively. Additionally, a thorough review and consideration by the person in charge was required to ensure that all relevant adverse incidents were reported to the Chief Inspector in the recommended formats and within the specified time frames, to ensure compliance with the regulatory requirements for notification of incidents to the Chief Inspector.

Judgment: Not compliant

Quality and safety

This section of the report provides an overview of the quality and safety of the service provided to the residents living in the designated centre. Overall, inspectors found that the provider was endeavouring to support residents in a person-centred manner. However, improvements were required to communication supports available to residents, the premises, safe storage of medicines, and restrictive practices used within the designated centre.

There were arrangements in place that ensured residents were provided with adequate nutritious and wholesome food that was consistent with their dietary requirements and preferences. Residents were encouraged to eat a varied diet, and equally their choices regarding food and nutrition were respected. Residents were supported by a coordinated multidisciplinary team, such as medical, speech and language therapy, and during the inspection staff were observed to adhere to advice and expert opinion of specialist services.

The provider had mitigated against the risk of fire by implementing suitable fire prevention and oversight measures. There were suitable arrangements in place to detect, contain and extinguish fires within the designated centre. There was documentary evidence of servicing of equipment in line with the requirements of the regulations. Residents' personal evacuation plans were reviewed regularly to ensure their specific support needs were met.

The person in charge ensured that there were appropriate and suitable practices relating to medicine management within the designated centre. This included the administration of medicines, medicine audits, medicine sign out sheets and ongoing oversight by the person in charge and service manager. However, some improvements were required to the safe storage of all medicines within the designated centre.

Where required, psychology and positive behaviour support plans were developed for residents, and staff were required to complete training to support them in helping residents to manage their behaviour that challenges. The provider and

person in charge ensured that the service continually promoted residents' rights to independence and a restraint-free environment. However, some improvements were required to ensure all restrictive practices used within the designated were identified as such, appropriately risk assessed, and notified to the Chief Inspector.

Good practices were in place in relation to safeguarding. Inspectors found that appropriate procedures were in place, which included safeguarding training for all staff, the development of personal and intimate care plans to guide staff and the support of designated safeguarding officers within the organisation.

All residents residing in this designated centre were identified as having specific communication support needs. However, during the inspection, there were no established communication support plans on file developed by qualified multidisciplinary professionals. This was particularly relevant and important given the frequent use of agency and relief staff, who might not be familiar with the residents' unique communication requirements. In such cases, it is crucial that communication support plans are developed by a multidisciplinary professional in order to provide clear guidance and recommendations to staff on effective communication and strategies to use.

During the inspection, a number of maintenance issues were identified that warranted thorough review and prompt attention from the provider.

Inspectors observed noticeable wear and tear and some areas of damage throughout the premises, including scuffed and worn hallway walls and doors, damage to the walls within residents' bedrooms, and wear and tear on furniture such as sofas used by the residents. Addressing these maintenance deficits was required to ensure residents were provided with a safe, comfortable, and welcoming environment.

Furthermore, it was identified that the design and layout of one resident's bedroom did not meet their current assessed needs. This also required thorough consideration and review by the provider.

Regulation 10: Communication

Improvements were required to ensure that all residents were assisted and supported at all times to communicate in line with their needs and wishes.

All residents living in this centre were identified as having communication support needs. However, upon a detailed review of individual assessments for three residents, one inspector observed that the communication support plans in use had not been informed by input from relevant multidisciplinary professionals. Furthermore, there were no documented communication assessments in the residents' files to support the recommendations outlined in their care plans. The

person in charge confirmed that none of the residents had undergone a communication assessment or review by a speech and language therapist.

Communication support plans indicated that some residents were more comfortable interacting with familiar people and were less comfortable in doing so with unfamiliar people. Given the frequent use of agency staff in the designated centre, this approach did not align with the residents' assessed preferences and needs. This discrepancy called for a thorough review and careful consideration by the provider.

The person in charge had submitted a referral to their multi-disciplinary team in April 2025, requesting an assessment by a multidisciplinary professional for one resident. The goal of this referral was to explore the potential use of assistive technology to enhance the resident's communication skills. This was also identified by the resident during their recent "My Life Meeting". However, the multidisciplinary team responded that the communication service was closed to all new referrals at that time. A follow-up referral was made in July 2025, and it was confirmed that the service remained closed, with an appointment to be scheduled once availability arose. Consequently, there was no clear plan or support in place to ensure that the resident could effectively utilise assistive technology to improve their communication skills.

Judgment: Not compliant

Regulation 17: Premises

Improvements were required by the provider to ensure that the premises was kept in a good state of repair, and met the assessed needs of all residents living in the designated centre.

During the inspection, inspectors identified a number of maintenance issues that detracted from the welcoming atmosphere of the designated centre.

For example, the following was observed:

- Noticeable damage to hallway walls and a radiator cover that needed replacing
- Damage to residents' bedroom door architraves and bathroom doors
- Damage to residents' bedroom walls which required attention
- Damage to utility room presses
- Skirting boards throughout the centre were noticeably dirty and required deep cleaning
- Broken towel rail in the bathroom
- Sofas in the sitting room were damaged and required replacing
- To enhance the homely ambiance, all resident bedrooms and shared spaces required repainting.

Furthermore, the layout of one resident's bedroom necessitated a review by the provider. Inspectors noted that the bedroom offered limited storage and space, and was not configured to meet the resident's current assessed needs.

For example, essential assistive equipment, such a wheelchair and a stand-assist hoist, were stored within the bedroom, which not only reduced available space but also compromised the resident's ability to evacuate swiftly in case of an emergency. On the day of inspection the provider had no clear plan or solution in place to address these concerns.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents with assessed needs in the area of feeding, eating, drinking and swallowing (FEDS) had up-to-date FEDS care plans on file. Plans had been appropriately informed and reviewed by a qualified member of the provider's multidisciplinary team. One inspector reviewed two FEDS care plan and found that there was comprehensive guidance regarding the residents' meal-time requirements including food consistency, equipment and environment and strategies and recommendations to be implemented.

Staff spoken with were very knowledgeable regarding residents' care plans and were observed to adhere to the directions from specialist services such as speech and language therapy. Staff were observed throughout the inspection to adhere to therapeutic and modified consistency dietary requirements as set out in FEDS care plans. For instance, one staff member was observed by an inspector to follow clinical guidelines when making a resident a cup of tea. Another inspector observed staff preparing the evening meal for residents, which one of the resident’s had chosen. The staff member spoke to the inspector about adaptations they were making to the meal in order to comply with recommendations as set out in residents' care plans.

Residents were consulted with and encouraged to lead on menu planning and were provided with opportunities to participate in the preparation, cooking and serving of their meals as they so wished. Inspectors noted a visual board displayed in the kitchen detailing the meals for the week which residents had decided on during their weekly house meeting. Food prepared appeared appetising and it was served in an appropriate way to ensure that residents enjoyed their food.

Inspectors observed a diverse 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 also well-equipped with high-quality cooking appliances and utensils, providing residents with everything needed to prepare their own meals.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had mitigated against the risk of fire by implementing suitable fire prevention and oversight measures. For example, inspectors observed break glass alarm points, smoke and heat detectors, and emergency lighting. Portable firefighting equipment was strategically located throughout the centre to cover the risk of fire.

Inspectors noted that escape routes through the centre were clearly indicated. Following a review of servicing records maintained in the centre, inspectors found that these were all subject to regular checks and servicing with a fire specialist company.

It was observed that the fire panel was addressable and easily accessed in the entrance hallway of the designated centre and all fire doors, including bedroom doors closed properly when the fire alarm was activated. All fire exits were equipped with thumb lock mechanisms, which ensured prompt evacuation in the event of an emergency.

The provider had put in place appropriate arrangements to support each resident's awareness of the fire safety procedures. For example, one inspector reviewed five residents' personal evacuation plans. Each plan detailed the supports each resident required when evacuating in the event of an emergency. Staff spoken with were aware of the individual supports required by residents to assist with their timely evacuation. In addition, it was noted that each resident had an easy-to-read personal evacuation plan on display in each of their bedrooms.

One inspector examined the fire safety records, including fire drill documentation, and confirmed that regular fire drills were conducted in accordance with the provider's established policy. The provider demonstrated that they were capable of safely evacuating residents under both day time and night time conditions.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were appropriate practices and arrangements for the management of residents' medicines, including for the ordering, and administration of medicines. However, improvements were required to the storage of medicines within this designated centre.

Residents were in receipt of a comprehensive individualised service from their pharmacist who facilitated the safe and timely supply of medicines, as well as information and pharmaceutical care to ensure the best possible outcome for each resident living in the centre.

Inspectors found evidence to support that each resident's medicines were administered and monitored in line with best practice as individually and clinically indicated. For example, one inspector reviewed and observed the practices and arrangements for one resident on two separate occasions during this inspection. The inspector also reviewed the resident's prescription sheet and medicine administration records. These documents contained all necessary information, and evidenced that the resident received their medicines as prescribed. Following observations and discussions with staff, it was evident to the inspector that staff were knowledgeable of the professional guidelines and professional code of practice that governed medicines management and adhered to these requirements.

Inspectors found that there were good arrangements for the oversight of medicine practices, including regular audits and checklists, to ensure that the provider's policy was adhered to and that any discrepancies were identified. There was a clear focus on medicines management, monitoring and review which aimed to reduce medicine related incidents and adverse events in the centre. For example, medicine error forms were completed as required and learning from this was used to further support staff knowledge and understanding and mitigate the risk of future errors occurring.

Improvements were required to the safe storage of all medicines within the designated centre. For instance, one inspector noted that a resident's PRN medicine was stored in a Tupperware container in the kitchen fridge.

This approach was failing to align with the provider's medication management policy in relation to safe storage of medication and posed a potential safety risk and required improved and more secure storage arrangements.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

One 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:

- Emotional wellbeing
- Mobility
- Money management
- Feeding, eating, drinking and swallowing (FEDS)
- Rights
- Personal intimate care.

Another inspector reviewed the personal plans of two residents, which were presented in an accessible format and detailed each resident's unique goals, wishes, and aspirations for 2025. These plans were personalised and reflected the individual needs and desires of each resident.

In addition, all residents had either attended or were scheduled to attend a "My Life Meeting". These meetings actively involved the residents, when they chose to participate, alongside their representatives, the person in charge, and key staff members. During these meetings, residents set meaningful goals they aimed to achieve. Examples of these 2025 goals included going on holidays, purchasing a fish tank, celebrating a birthday, enjoying a hotel break, continuing a healthy eating plan, and going on a boat trip with peers.

Judgment: Compliant

Regulation 7: Positive behavioural support

Inspectors found that effective arrangements were in place to provide positive behaviour support for residents with assessed needs in this area. However, improvements were required to the identification, documenting, and reporting of all restrictive practices used in the designated centre.

Residents had up-to-date positive behaviour support plans on file. One inspector reviewed two residents' plans and found that these were detailed, comprehensive and developed by an appropriately qualified person. Each plan demonstrated a comprehensive positive behaviour support approach was being implemented.

Plans included trigger and antecedent events outlining the cause of the resident's behaviour had been assessed and determined. The plan's proactive and preventive strategies worked towards mitigating the risk of behaviours that challenge from occurring.

The provider ensured that staff had received comprehensive training, equipping them with the knowledge and skills required to support residents effectively. Staff spoken with were knowledgeable of support plans in place and both inspectors observed engaging and positive communications and interactions throughout the inspection between residents and staff.

Prior to this inspection, a comprehensive review of all restrictive practices notified to the Chief Inspector on a quarterly basis was undertaken. A total of seven restrictive

practises were notified, encompassing environmental, mechanical, and chemical restraints. The inspector confirmed that these had been appropriately risk assessed, in accordance with the provider's established policy, and were subject to regular review by the provider's positive approaches monitoring group (PAMG).

However, during the inspection inspectors identified a further two restrictive practices in use which had not been identified by the provider, risk assessed, approved by the provider's PAMG, or notified to the Chief Inspector. For example, residents' personal monies were securely stored and accessed by staff. Additionally, hourly night checks were being conducted on residents. There was no clear documentation or justification for their necessity or what risk or assessed need they were managing. This required further review and consideration through a rights based approach.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. For example, there was a clear policy in place with supporting procedures, which clearly directed staff on what to do in the event of a safeguarding concern. In addition, the provider had an established policy in place pertaining to the provision of personal intimate care.

Staff spoken with throughout this inspection were knowledgeable about abuse detection and prevention and promoted a culture of openness and accountability around safeguarding. In addition, staff knew the reporting processes for when they suspected, or were told of, suspected abuse. It was evident that staff took all safeguarding concerns seriously. Furthermore, all staff had completed safeguarding training equipping them with the skills necessary for the prevention, detection, and response to safeguarding issues.

On the day of this inspection there were no safeguarding concerns open. One inspector completed a review of previous safeguarding concerns and found that these had been reported and responded to as required. For example, interim safeguarding plans had been prepared with appropriate actions in place to mitigate safeguarding risks. The inspector reviewed two preliminary screening forms and found that any incident, allegation or suspicion of abuse was appropriately investigated in line with national policy and best practice.

Inspectors found that learning from investigations were used to inform changes in practice. In addition to staff safeguarding training, the provider, and person in charge put in place a number of other learning strategies to enhance the staff teams' knowledge and skill in safeguarding and better promote best practice in this area. For example, a comprehensive safeguarding audit was completed in December 2024 by the provider's senior safeguarding social worker and all findings and learning from this audit was shared with the staff team.

Following a review of three residents' personal intimate care plans by one inspector it was observed that safeguarding measures were in place to ensure that staff provided personal intimate care to residents who required such assistance in line with the residents' personal plans and in a dignified manner.

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
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sabhaile OSV-0002370

Inspection ID: MON-0039499

Date of inspection: 16/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• The Registered provider together with the Human Resources Department is continuing an active recruitment drive to fill all current vacancies in the Designated Centre on a permanent basis
Date: 31/03/2026

• A newly recruited nurse and direct support worker have been recruited for the relief panel and have almost completed their compliance checks, including references and medicals. The Relief Coordinator has allocated these staff to the designated centre to backfill existing vacancies while recruitment for permanent staff continues
Date: Will have commenced by – 01/12/2025

• Two additional members of the staff team have taken on driving duties, bringing the total number of qualified drivers in the designated centre to three. In addition, the newly recruited relief staff – the staff nurse and the direct support worker – are both qualified drivers and will be able to undertake driving duties as required
Date: 20/10/2025 Completed

• When recruiting new staff, priority will be given to candidates whose skills and experience align with the needs of the service, including the ability to drive within the designated centre
Date: Ongoing

• The Person in Charge will ensure there is a planned and working roster in situ each month and include the names of relief staff and agency staff in the working roster.
Date: 31/10/2025 & Ongoing

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• In line with the provider's supervision policy, the Person in Charge will ensure that all staff members receive supervision on a quarterly basis. A supervision plan has been implemented to ensure that each staff member has a scheduled quarterly supervision meeting and that no sessions are missed.
Date: 20/10/2025 Completed

• All staff supervision has been completed for quarter 3
Date: 20/10/25 Complete with future supervision meetings scheduled

• The Person in Charge has completed a supervision meeting with their line manager with next supervision scheduled for 20/01/2026
Date: 17/10/2025 Completed

• An alternative support structure is in place to ensure that the Person in Charge receive supervision and support in the event a service manager is on leave.
Date: 20/10/2025 Completed

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A roster review has been scheduled with the Person in Charge (PIC), Service Manager, and Administration Manager. The review will include an assessment of the current rostered hours and staffing requirements, with a view to determining whether scope exists within the current whole-time equivalent to allocate additional management hours to the PIC.
Date: by 30/11/2025

• The PIC has purchased a small lockable fridge designated specifically for the storage of medications that require refrigeration. Daily temperature checks will be completed and recorded in line with organizational policy and procedures.
Date: 20/10/2025 Complete

• The centre will review and strengthen its auditing processes to ensure all audits accurately reflect current practices and promptly identify any issues.
Date: 31/12/2025 In progress

• A new Service Manager has been appointed and will provide ongoing support to the

Person in Charge (PIC) in the effective management of the centre. The Director of Nursing, who is also the PPIM for the centre, is available to support the PIC in the absence of the Service Manager, ensuring continuity of governance and oversight.
Date: 30/10/2025 Completed

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Outstanding notifications submitted retrospectively via HIQA Portal
Date: Completed 21/09/2025

• The PIC has had a one-to-one meeting with the Quality and Risk Manager regarding their responsibilities as a Person in Charge (PIC), specifically in relation to HIQA notifications and restrictive practices.
Date: Completed 09/10/2025

• PIC to complete a review of all relevant adverse incidents
Date: Completed 20/10/2025

• PIC and PPIM will ensure that future adverse incidents are reported to the Chief Inspector within the specified time frames, to ensure compliance with the regulatory requirements for notification of incident

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• The Speech and Language Therapist has updated the communication guidelines for three residents to ensure their current needs are supported. The PIC has ensured that all three residents individual communication support plans were updated in line with current clinical guidelines. Date Completed 20/10/2025

• The PIC has sent a communication referral for two residents to the Speech and Language Therapy Department. The Speech and Language Therapy Manager has advised that they will re-open the waitlist for new referrals in in November 2025 pending successful recruitment. The communication assessments, including exploration of assistive technology options will commence by the 30/04/2026.

• In the interim, the PIC in consultation with the two residents and their support circle

will develop communication support plans which details their individual communication supports, non-verbal communication methods, and outlines the supports required to maximise opportunities for communication with both familiar and unfamiliar staff. Date 30/11/25.

• As part of ongoing efforts to improve care, the Registered Provider, in collaboration with the HR Department, continues the recruitment drive and has block-booked a relief nurse and a direct support worker who are currently being on boarded. This initiative will support continuity of care and ensure consistent staffing by personnel familiar with residents' needs, including their communication requirements. In cases where agency staff are required, the PIC ensures that they receive appropriate orientation and are briefed on each resident's specific communication needs, with particular attention given to those who may be less comfortable with unfamiliar people.
Date: 31/12/2025 In progress

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A full scope of works for the premises has been developed following a site visit by the Chief Assistant Technical Services Officer to address the required repairs and redecoration of the centre. The agreed works have been incorporated into the organisation's maintenance plan, with a defined timeframe for completion – see below

o Noticeable damage to hallway walls and a radiator cover that needed replacing Date : 28/02/2026
o Damage to residents' bedroom door architraves and bathroom doors Date:28/02/2026
o Damage to residents' bedroom walls which required attention Date:28/02/2026
o Damage to utility room presses Date: 28/02/2026
o Skirting boards throughout the centre were noticeably dirty and required deep cleaning Date: 28/02/2026
o Broken towel rail in the bathroom Date: 28/02/2026
o Sofas in the sitting room were damaged and required replacing Date:28/02/2026
o To enhance the homely ambiance, all resident bedrooms and shared spaces required repainting. Date: 28/02/2026

• The door closer on one resident's bedroom door will be replaced to allow for swift entry and exit, as well as the reorientation of the room to optimise space in line with the resident's current assessed needs.
Date: 28/02/2026

• In line with the organization's procurement policy, a replacement for the damaged sofa has been approved for purchase. 28/02/2026

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A medication fridge with a lock feature has been purchased to ensure proper medication storage within the designated centre. The fridge will be subject to regular temperature checks and audits in accordance with the Safe Administration of Medication policy.
Date: 20/10/2025 Complete

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The PIC met with residents to discuss the management of their personal finances within the centre. Alternative arrangements have been implemented for the storage of each resident's money, in accordance with their individual wills and preferences. Each resident's money management support plan has been updated to reflect these changes in practice.
Date:20/10/2025 Complete

• The practice of nightly checks on residents has been discussed and risk assessed with the relevant clinician. Routine nightly checks on residents are no longer in place.
Date: 20/10/2025 Complete

• Nightly checks will only be carried out when an identified need exists, such as a clinical requirement, and will be conducted in accordance with the Restrictive Practice policy. This directive has been communicated to all staff by the Person in Charge (PIC) and was further discussed at the team meeting.
Date: 21/10/2025 Complete

• The Organisation's policy on restrictive practices was discussed at the staff meeting to ensure that all staff are clear and up to date on the processes and procedures involved in the use of restrictive practices.
Date: 21/10/2025 Complete

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	30/04/2026
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	30/11/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	31/03/2026

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/12/2025
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	31/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2025
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	28/02/2026
Regulation 17(1)(b)	The registered provider shall	Not Compliant	Orange	28/02/2026

	ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	28/02/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	30/12/2025
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	20/10/2025
Regulation 23(3)(a)	The registered provider shall ensure that effective	Substantially Compliant	Yellow	20/10/2025

	arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	01/10/2025
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.	Not Compliant	Orange	21/09/2025
Regulation 31(3)(a)	The person in charge shall	Not Compliant	Orange	09/10/2025

	ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	21/10/2025