



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

Issued by the Chief Inspector

Name of designated centre:	Shanowen/Shanvarna
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	14 January 2026
Centre ID:	OSV-0002374
Fieldwork ID:	MON-0044851

About the designated centre

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

Shanowen is a designated centre operated by St. Michael's House. This centre comprises of two houses and provides a full-time residential service for a maximum of six adults over the age of 18 years with intellectual disabilities. Each residential house is within a short walking distance from each other and located in a community setting in North Dublin One house is a single storey residence comprising of five bedrooms, a wheelchair accessible bathroom, a shower room, a kitchen/dining room, living room and a quiet room for five residents. The second house is a single occupancy living arrangement consisting of a bedroom, staff office, staff sleep over room, spacious kitchen dining area and living room. The centre is staffed by social care workers and managed by a full-time person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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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 14 January 2026	10:20hrs to 17:30hrs	Karen McLaughlin	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the ongoing regulatory monitoring of the centre. The inspection focused on how residents were being safeguarded in the centre. Safeguarding is one of the most important responsibilities for a provider.

To assess the quality of life for the residents the inspector relied on a combination of observations, discussions with residents, a review of relevant documentation, and conversations with key staff members.

The inspector determined that, overall, residents received high-quality care provided by a familiar staff team who delivered it with kindness and respect. However, there were areas that required improvement relating to training and staff development and residents individual assessments and personal plans. These are all discussed further in the main body of the report.

The centre was registered to accommodate six adult residents across two houses in close proximity to each other.

The inspector conducted a walk-through of both premises accompanied by the person in charge. Overall, both premises were homely and suitable to meet the assessed needs of residents. There was adequate private and communal accommodation for the residents.

Both properties floor plans were clearly displayed alongside the centre's fire evacuation plan in the hallway. The hallway also had the centre's certificate of registration, residents' guide, visitors policy and complaints procedure on display.

Residents' bedrooms were nicely decorated in line with their preferences and wishes, and the inspector observed the rooms to include family photographs, and memorabilia that was important to each resident.

However, in one of the houses works due to be completed following the last inspection, namely works to improve accessibility of one bathroom and suitable access to the garden area had not been completed. On the day of the inspection, the person in charge showed evidence that these works would be completed by May 2026.

On the day of the inspection, some residents attended day services, while others relaxed in the centre which was in line with their will and preferences.

Residents were observed to lead busy and active lives, expressing satisfaction with their home and the staff who supported them. They shared their enjoyment of activities such as doing the laundry, going out for coffee, and grocery shopping.

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 inspector sat at the kitchen table with two residents who were having breakfast. With the support of the staff on duty, the inspector explained why she was there and asked the residents if they would speak with her about their experiences of living in the centre. One resident spoke about how they spent the Christmas break and about a recent family holiday. The other resident showed the inspector their bedroom and their work training portfolio.

Later in the afternoon, another resident returned from her day service and stopped in the kitchen to have a coffee and a snack and tell staff about her day.

Many of the residents had enjoyed holidays over the summer. Residents talked about how much they had enjoyed these trips and about other trips which they were planning.

From speaking with residents and observing their interactions 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 service was operated through a human rights-based approach to care and support, and residents were being supported to live their lives in a manner that was in line with their needs, wishes and personal preferences.

The next two sections of the report will describe the governance and management arrangements in the centre and how these were effective in ensuring there were appropriate safeguarding practices in the centre, as well as a description of the quality and safety of care of residents, with a particular focus on safeguarding.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations with a particular focus on safeguarding.

Safeguarding is a critical responsibility for providers in designated centres. All residents have the right to safety and to live free from harm, which is essential for delivering high-quality health and social care. Residents should be able to trust the provider, person in charge, and the staff to help them feel secure. Therefore, effective safeguarding depends on collaboration among individuals and services to ensure that residents are treated with dignity and respect, and are empowered to make decisions about their own lives.

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.

However, the arrangements to ensure that residents' needs were being fully met in the centre required improvement.

In particular, while there were management and oversight systems in place to support the delivery of a service that was safe and appropriate, the provider's arrangements for completing personal plans and documentation pertaining to residents care and support needs required improvement.

A review of the roster demonstrated that staffing levels and skill mix were appropriate to meet the assessed needs of the residents. There was a planned and actual roster maintained for the designated centre. Rotas were clear and showed the full name of each staff member, their role and their shift allocation.

The staffing levels in place in the centre were suitable to meet the assessed needs and number of residents living in the centre. Warm, kind and caring interactions were observed between residents and staff and staff were observed to be available to residents should they require any support and to make choices.

The inspector spoke with staff members on duty throughout the course of the inspection. The staff members were knowledgeable on the needs of each resident, and supported their communication styles in a respectful manner.

Appropriate training is fundamental in supporting staff to understand behaviours that challenge and promoting environments that respect residents' rights and dignity. The provider had not ensured that all staff who worked with residents who needed behaviour support had up-to-date skills or training in positive behaviour support. Additionally, enhancements were required to the supervision arrangements for all staff to ensure they received appropriate support and supervision from qualified and experienced personnel.

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

Regulation 15: Staffing

On the day of this inspection, the provider ensured there were sufficient staffing levels with the appropriate skills, qualifications, and experience to meet the assessed needs of the residents at all times, in accordance with the statement of purpose and the size and layout of the designated centre.

The inspector examined the planned and actual staff rosters for December 2025 and January 2026. It was found that regular staff were employed, and the rosters accurately represented the staffing arrangements, including the full names of staff on duty during both day and night shifts.

During the inspection, the inspector spoke with two staff members on duty and found that all were knowledgeable about the residents' support needs and their responsibilities in providing care. Residents were familiar with the staff and felt comfortable interacting and receiving care. It was clear that staff had developed and maintained therapeutic relationships with residents, helping them feel safe, secure, and protected from all forms of abuse.

Judgment: Compliant

Regulation 16: Training and staff development

Staff working in the centre had access to training as part of their continuous professional development and to support them in the delivery of effective care and support to residents living in the centre.

There was a training matrix in place that supported the person in charge to monitor, review and address the training needs of staff.

The inspector reviewed the training records for staff working in the centre and found that there were some gaps in refresher training in positive behavioural supports, fire safety and hand hygiene.

The person in charge was responsible for the provision of supervision and support to all staff members within the designated centre. According to the provider's policy, staff were to receive four formal supervision sessions per year. The inspector reviewed the supervision schedule for 2025 and noted that there was significant gaps in the provision of supervision, with 6 staff members only receiving 1 formal supervision session in the 12 month period. As a result, the inspector was not assured that staff were in receipt of supervision and support relevant to their roles.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre was sufficiently resourced. For example, there was sufficient staff available to meet the needs of residents, adequate premises, facilities and supplies and residents had access to a transport vehicle which was assigned for the centre's use only.

There were clearly defined management arrangements in the centre. The centre was staffed by a team of social care workers who reported to the person in charge. Staff members spoken with were informed of the reporting arrangements and of

how to escalate any concerns, including safeguarding concerns, to the person in charge and to the designated officer.

The registered provider had implemented management systems to monitor the quality and safety of service provided to residents, for example, annual reviews, six-monthly reports, and a suite of other audits were carried out. These audits identified any areas for service improvement.

However, the inspector noted that while clear lines of authority and accountability were in place within the designated centre, this inspection highlighted a number of key areas where improvements were required in oversight and local management systems. Specifically, enhancements were needed in staff development and in the documentation of individual assessment and personal plans.

A review of monthly staff meetings from October and November showed regular discussions on all audit findings, including the documentation of residents plans and a plan in place to progress updating the documents in a timely manner.

Judgment: Substantially compliant

Quality and safety

This section of the report provides an evaluation of the quality of services delivered and the effectiveness of measures implemented to ensure the safety of residents. Regulations pertaining to safeguarding were specifically assessed as a part of this inspection.

The inspector found the atmosphere in the centre to be warm and relaxed, and residents appeared to be very happy living in the centre and with the support they received. There was adequate private and communal spaces and residents had their own bedrooms, which were being decorated in line with their tastes.

Overall, a good quality of service was provided to all residents, and during this inspection, the inspector observed residents expressing their choices to staff regarding what they wanted to do and when they needed support.

However, the inspector observed that substantial improvements were necessary concerning individual assessments and personal plans for the residents living in this designated centre.

Throughout the inspection, the inspector observed that staff demonstrated flexibility and adaptability in their use of various communication strategies. Additionally, residents had access to safeguarding information presented in formats appropriate to their communication styles and abilities.

Where required, positive behaviour support guidelines were developed for residents and staff members spoken with on the day of this inspection were knowledgeable about guidelines in place. The provider and person in charge ensured that the service continually promoted residents' rights to independence and a restraint-free environment.

Good practices were in place in relation to safeguarding. The inspector found that appropriate procedures were in place, which included safeguarding training, the development of personal intimate care plans to guide staff and the support of a designated safeguarding officer within the organisation. Any incidents or allegations of a safeguarding nature were investigated in line with national policy and best practice. Where a concern arose for a resident's safety the staff team and management took timely and proportionate measures to protect the residents involved.

The inspector saw that staff practices in the centre were upholding residents' dignity and were supporting residents to have control over their lives. Residents were continually consulted about and made decisions regarding the ongoing services and supports they received, and their views were actively and regularly sought. Information was made available to residents in a way that they could understand in order to support them to make informed choices and decisions. On the day of the inspection, two residents were planning a trip to the cinema and the inspector observed staff supporting both residents in the planning of this activity.

Overall, residents were provided with safe and person-centred care and support in the designated centre, which promoted their independence and met their individual and collective needs.

Regulation 10: Communication

The inspector found that residents were supported by staff who understood their communication needs and could respond appropriately.

Staff were observed to be respectful of the individual communication style and preferences of the residents.

Some residents required support to engage in conversations with the inspector. The inspector saw that staff members clearly understood residents' communications and were able to support conversations.

Throughout the duration of the inspection, the inspector observed residents receiving information and being communicated with in the best way that met their assessed needs.

Residents had access to telephone and media such as radio and television.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed four residents' assessment of need and personal plans. It was found that not all residents had an up-to-date and comprehensive assessment of need on file, with a poor level of goal tracking.

The person in charge had not ensured assessments of residents' needs were completed and consequently the development of personal plans. Both the providers six monthly unannounced audits identified significant gaps in the recording of documentation of residents personal plans.

One resident's file showed no input of goal progress in the past 12 months and another showed that a residents assessment of need had not been updated for the year 2025. These assessments are used to inform care and support plans for the residents. Therefore the inspector could not be assured that the supports required to maximise each resident's personal development, in accordance with their assessed needs, were reviewed annually or sooner, taking into account changes in circumstances and new developments.

These gaps had been discussed at the centres last three staff meetings and a plan put in place with specific timescales to update residents files. Nonetheless, the recording of important information required more consideration and the inspector found the associated documentation required improvement to better demonstrate their progress.

This presented a risk to the clarity and accuracy of documentation, which was essential for ensuring residents were provided with safe and person-centred care and support at all times.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with this. Clear behaviour support plans were in place to guide staff on how best to support these residents, and regular multi-disciplinary input was sought in the review of residents' behavioural support interventions.

The inspector found that the person in charge was promoting a restraint-free environment within the centre. The inspector completed a review of restrictive

practices in place in the centre and found that all restrictive practices were logged, regularly reviewed and risk assessed in line with the provider's policy.

Judgment: Compliant

Regulation 8: Protection

A review of safeguarding arrangements noted, for the most part, residents were protected from the risk of abuse by the provider's implementation of National safeguarding policies and procedures in the centre.

The registered provider and person in charge had established systems to safeguard residents from abuse. For instance, a clear policy was in place, providing staff with explicit guidance on the appropriate actions to take in the event of a safeguarding concern. Furthermore, all staff had completed safeguarding training equipping them with the skills necessary for the prevention, detection, and response to safeguarding issues.

Safeguarding incidents were notified to the safeguarding team and to the Chief Inspector in line with regulations.

At the time of this inspection there were no safeguarding concerns open. However, the inspector's review of preliminary screening forms evidenced that the information provided was both comprehensive and detailed. Additionally, interim and formal safeguarding plans, where necessary, were incorporated as part of this process.

Furthermore, safeguarding was discussed regularly at staff meetings and guidance given about what actions to take in the event of a case of suspected abuse.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that the centre was operated in a manner that respected residents' rights, needs, and choices, thereby supporting their welfare and promoting self-development.

The provider had fostered a culture where a human rights-based approach to care was central to how residents were supported. Throughout the inspection, the use of this approach was evident, empowering residents to live lives of their choosing, guided by human rights principles. For example, residents had control over their daily routines, making choices based on their personal values, beliefs, and preferences.

The inspector saw that staff interactions with residents were in a manner which upheld residents' dignity and provided residents with choice and control.

Staff were seen offering residents choices, responding to residents needs and requests by providing direct assistance in a manner which respected residents' right to dignity and privacy.

Residents were observed to engage in meaningful activities in line with their likes and personal preferences throughout the inspection.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Shanowen/Shanvarna OSV-0002374

Inspection ID: MON-0044851

Date of inspection: 14/01/2026

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 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <ul style="list-style-type: none"> • The training matrix has been reviewed and updated to reflect completed training. It is now 85 % compliance and expected to be at 95% by 31.03.2026. • All staff have been booked for outstanding training to include positive behavior supports, fire safety and hand hygiene and will be completed by 31.03.2026 • All staff have received quarter one supervision. • The PIC has developed a supervision tracker for 2026 to ensure all staff have four supervision sessions per year as per policy. • The PIC and Service Manager will review supervision tracker at management meetings. 	
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"> • The provider will continue to complete six monthly audits. • The provider will continue to complete management meetings with the PIC. • PIC to complete monthly data reports and submit to the service manager monthly for discussion at Service Manager/PIC management meetings. • PIC to complete all local audits as required by the provider. Completion of audits will be discussed at Service Manager/PIC Management Meetings. • The PIC to complete supervisions as per provider policy. • The PIC and Service Manager will review team supervision at management meetings and discuss staff performance regarding personal plans and personal development. • Team Support & Development meeting was held on 22.01.2026, where Service Manager, PIC and team discussed areas for improvement and an agreed action plan. 	

• PIC and Team SMART Support and Development Plans implemented on 16.02.2026 and will be reviewed by PIC and Service Manager by 06.03.2026.

Regulation 5: Individual assessment and personal plan

Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

- All residents now have an up-to-date Assessment of Need
- All residents have support plans in place that are in date and reviewed quarterly.
- All residents have identified goals for 2026, and the residents and keyworkers are now actively tracking.
- All residents now have an up to date All About Me for 2026 in a format of the residents choosing.
- About Me meetings have either been completed for 2026 or a date scheduled.
- All relevant guidelines have been reviewed and updated as required,
- All relevant individual risk assessments have been reviewed and updated.
- The providers Person Centered Planning Co-Ordinator will provide refresher PCP (Person Centred Planning) training to the team by 31st March 2026.
- A local Person Centre Planning lead has been identified in the centre- they will lead out in auditing the PCP folders ensuring all documentation is in place and updated as required.
- PCPs have been added to the team meeting staff meeting as a standing agenda item. Each keyworker will provide monthly PCP updates at this meeting for the key client.
- PIC will include PCP updates on supervision agenda with team members. |

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 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	31/03/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2026
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for	Substantially Compliant	Yellow	31/03/2026

	the quality and safety of the services that they are delivering.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/03/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/03/2026