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:	Donabate Residential
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	02 December 2025
Centre ID:	OSV-0003597
Fieldwork ID:	MON-0044772

About the designated centre

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

Donabate Residential is a designated centre operated by St Michael's House. The centre provides a full-time community residential service for up to six adults with intellectual disabilities and can also support residents with health care support needs. Donabate Residential comprises of a seven bedroom bungalow, located in North Dublin. The centre is managed by a Clinical Nurse Manager and is staffed by a team of staff nurses, social care workers, and health care assistants.

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 2 December 2025	09:00hrs to 17:00hrs	Kieran McCullagh	Lead

What residents told us and what inspectors observed

This unannounced inspection was conducted to evaluate the quality and safety of care provided to residents. It focused on how residents were being safeguarded in the centre and was prompted by solicited information submitted to the Office of the Chief Inspector, raising concerns about care standards at this designated centre.

The inspector determined that, overall, residents received quality care provided by a familiar staff team who delivered it with kindness and respect. However, ongoing resident incompatibility and safeguarding concerns led to areas of non-compliance under training and staff development, governance and management, protection, and residents' rights. Furthermore, improvements were required under other regulations, including staffing, and individual assessment and personal plans.

The inspection was conducted by one inspector over the course of one day and was facilitated by the person in charge. To gather an impression of what it was like to live in the centre, the inspector observed daily routines, spent time discussing residents' specific needs and preferences with staff, and completed a documentation review in relation to the care and support provided to residents.

The designated centre is currently registered to accommodate six residents. On the day of the inspection there were five residents living in the designated centre. The inspector had the opportunity to meet and talk with all residents living there. The designated centre is a large bungalow located in a quiet cul-de-sac in a small coastal town in North County Dublin. The house comprised of seven bedrooms including one staff sleepover room, kitchen, dining room, sitting room, utility room, sensory room, two large accessible bathrooms and a staff office. The local village was a five minute walk from the designated centre and residents were supported and encouraged to use the local facilities and amenities, which included a supermarket, post office, barbers, hairdressers, library and gym.

The inspector completed a walk around of the centre. Each resident had their own bedroom which was decorated to their individual style and preference. The communal living areas included two sitting rooms, a kitchen dining area, and a large back garden, that provided outdoor seating for residents to use, if they wished. There were a number of bathrooms, a utility room with laundry facilities, staff office, and a staff sleepover room. Equipment used by residents, such as electric beds and a shower bed, was observed to be in good working order.

Residents in the centre presented with a variety of communication support needs and were supported by staff to communicate and interact with the inspector throughout the inspection. On the day of this inspection, one resident attended their day service programme, one resident was in receipt of an individualised service, and three residents received care and support from home due to various appointments and day service closures. The inspector 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.

Residents had active and busy lives outside of the designated centre. For example, they had been on holidays, were active members of their local community and utilised the local services, attended day service programmes, and participated in activities of their own choosing. For instance, on the day of this inspection one resident was supported to go out for the day and have lunch out, which they enjoyed. Residents each had their own keyworker, engaged well in the person-centred planning process, and had set goals for 2025. Staff spoken with acknowledged that residents were happy and content while they were engaged in activities, however, voiced concerns regarding residents' wellbeing during the evening and weekends when all residents were home together. This was a direct result of ongoing compatibility and safeguarding concerns, and is discussed further under Regulation 9: Residents' rights.

The inspector engaged in detailed discussions with the person in charge, with a particular focus on the volume of safeguarding concerns notified to the Chief Inspector since January 2025, and the ongoing compatibility concerns within the designated centre. Safeguarding incidents included loud vocalisations negatively impacting on residents, peer to peer compatibility issues, and instances of self injurious behaviours as a result of compatibility issues within the designated centre. During the inspection the inspector observed instances of loud vocalisations throughout the morning, and could understand how noise levels could negatively impact fellow residents. Space within the designated centre was limited and quiet time away from this was not always feasible.

The person in charge reported that efforts had been made to mitigate ongoing concerns including individual case management meetings, and fundraising for a garden room, which could be utilised to provide a quiet space for residents. However, on the day of this inspection there was no specific plan in place to address ongoing concerns. Furthermore, the inspector voiced concerns that there was one resident vacancy and potential for admitting another resident into the designated centre while compatibility and ongoing safeguarding concerns remained.

Staff spoken with throughout this inspection voiced concerns in relation to compatibility of residents and ongoing safeguarding concerns. The inspector noted that staff working in the designated centre were skilled, and knew the residents' likes and preferences. However, following a review of the staff training matrix, it was evidenced that not all staff had up-to-date mandatory training in critical areas such as fire safety, positive behaviour support, and safeguarding of vulnerable adults. This was concerning given the high frequency incidents of behaviours that challenge and safeguarding concerns.

In response to the high levels of non-compliance found on this inspection, the Office of the Chief Inspector of Social Services invited the provider to attend an escalation meeting requiring the provider to bring the centre back into compliance.

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

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. There was a regular core staff team in place and they were knowledgeable of the needs of the residents and had a good rapport with them. 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. However, improvements were required concerning the staff rosters, specifically regarding the recording of the full names of relief and agency staff members on duty.

Appropriate training is fundamental in supporting staff to understand behaviours that challenge and promoting environments that respect residents' rights and dignity. The provider and person in charge had not ensured that all staff had up-to-date mandatory training in critical areas such as fire safety, safeguarding of vulnerable adults, and managing behaviour that challenges. Additionally, enhancements were required to the supervision arrangements for all staff to ensure they received appropriate support and supervision from qualified and experienced personnel.

During the course of this inspection, the inspector observed a number of critical areas where the governance and management structures appeared inadequate. Specifically, gaps in documentation and inaccurate reporting did not provide the inspector with sufficient assurance that that the provider had robust arrangements in place to ensure the delivery of a high-quality, safe service to residents and that national standards and guidance were being effectively implemented. Additionally, the provider's failure to address actions outlined in their compliance plan response following the previous inspection indicated a lack of effective oversight.

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 staff team was comprised of the person in charge, nurses, social care workers, and direct support workers. The inspector examined the planned and actual staff rosters for September, October, and November 2025. It was found that the provider was committed to ensuring continuity of care for residents within the service by utilising a small group of regular relief and agency staff to cover vacant shifts.

During the inspection, the inspector spoke with a number of staff members on duty and found that all were highly 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.

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

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed the most recent staff training records maintained in the designated centre.

Following review, the inspector noted the following:

- Eight staff required fire safety training
- Seven staff required training in managing behaviour that challenges
- Five staff required safeguarding training
- Seven staff required manual handling training
- Four staff required feeding, eating, drinking, and swallowing (FEDS) training.

Given the ongoing incompatibility and safeguarding concerns in the designated centre, the insufficient staff training created a risk to staff delivering safe, person-centred, and effective support to residents.

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. Following a review of five staff supervision records it was noted that one staff member had two supervision meetings so far in 2025, and one supervision meeting in 2024. In addition, four staff had only one supervision meeting so far in 2025.

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: Not 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 eight days, referred to as 'management days', per month. Considering the frequent safeguarding concerns and ongoing compatibility issues, 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.

In compliance with regulatory requirements, unannounced visits were conducted biannually of the designated centre. The inspector reviewed the report following the latest unannounced visit, which was completed in May 2025. Following the review, the inspector found that improvements were needed regarding the accuracy of recorded and reported information. For instance, while the report stated that no behaviours that challenge were present in the designated centre, a review of incidents from April to June 2025 revealed 60 instances of such behaviours had occurred.

Additional improvements were required to monthly data reports which were completed as part of governance arrangements and covered critical areas such as residents' wellbeing, support plans, accidents and incidents, safeguarding, and behaviours that challenge. The inspector reviewed monthly data reports for the months of October and November 2025. However, following review it was found

that inaccurate information pertaining to safeguarding concerns, and incidents of self injurious behaviours was documented. Gaps in recorded documentation highlighted a risk that critical information about residents' wellbeing and necessary supports required was not being properly documented or communicated to management.

Furthermore, the provider had failed to implement actions identified on their compliance plan response following the last inspection, which was completed in March 2024. For instance, designated fire exits had not been fitted with thumb lock mechanisms. The provider had stated that this would be complete by the end of April 2024. This presented a risk to all residents and impeded prompt evacuation in the event of a fire.

Judgment: Not 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. Overall, strategies in place to support residents were not effective and there remained an ongoing risk to residents of further safeguarding incidents occurring and negatively impacting on their lived experience and their human rights.

Safeguarding extends beyond the prevention of abuse, exploitation, and neglect. It involves a proactive approach, recognising safeguarding concerns, and implementing measures to protect individuals from harm. It is also about promoting the human rights of residents and empowering them to exercise control over their own lives. The provider lacked sufficient systems and processes to guarantee that residents were adequately protected and safe from harm. The existing safeguarding measures in the designated centre were ineffective in promoting and protecting residents' human rights, and wellbeing, as well as empowering them to safeguard themselves. Ongoing incompatibility issues and safeguarding concerns compromised residents' sense of security, and their right to a safe environment.

Staff knew each residents' communication requirements and the inspector observed throughout the inspection that staff were flexible and adaptable with all communication strategies used. The inspector observed residents expressing their choices to staff regarding what they wanted to do and when they needed support.

It was found that residents had comprehensive assessments of need on file. Care plans were derived from these assessments of need. Care plans were comprehensive and were written in person-centred language. However, improvements were required pertaining to the tracking and documentation of residents' goals.

Where required, positive behaviour and psychology support plans were developed for residents. The provider and person in charge ensured that the service continually promoted a restraint-free environment. For example, restrictive practices in use were clearly documented and were subject to review by appropriate professionals.

The provider had not ensured the centre was operated in a manner which was respectful to the rights of all residents, and ongoing incompatibility issues adversely impacted on residents' rights in their home. These compatibility issues impeded the overall quality and safety within the designated centre.

The provider had not ensured the centre was operated in a manner which was respectful to the rights of all residents, and ongoing incompatibility issues adversely impacted on residents' rights and dignity in their home. Furthermore, some residents were living in a designated centre that was not in line with their assessed needs resulting in frequent episodes of self injurious behaviours, and loud vocalisations which negatively impacted on all residents.

Overall, strategies in place to support residents were not effective and there remained an ongoing risk to residents of further safeguarding incidents occurring and negatively impacting on their lived experience and their human rights.

Regulation 10: Communication

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

Throughout the duration of the inspection the inspector observed residents freely expressing themselves, receiving information and being communicated with in the best way that met their assessed needs. For instance, a number of residents had communication challenges. Staff supporting these residents acted as communication partners and were observed to be familiar with the residents' communication support plans.

During the inspection, the inspector reviewed communication passports of two residents and found the information to be accurate and current. The plans were thorough, detailed, and created by a qualified professional. The inspector noted that comprehensive information pertaining to the following was included in communication passports:

- How I communicate during my favourite activities
- How I make choices
- How people in my life communicate with me
- How I communicate with you
- Things I like to communicate about.

Overall, the inspector found that residents were cared for by staff who understood their communication needs and could respond accordingly. Residents had access to information that was appropriate to their communication needs.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector completed a review of 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 instance, the inspector observed plans on file relating to feeding, eating, drinking and swallowing (FEDS), communication, emotional wellbeing, and positive behaviour support.

All residents were actively engaged in the person centred planning process, and the inspector saw evidence that residents had participated and engaged in "Wellness and Outcomes Meetings", and "My Life Meetings" throughout 2025. During these meetings, residents set meaningful goals they aimed to achieve. Examples of 2025 goals set included gardening, swimming, baking, meet family for lunch and coffee out, and go bowling once per month.

However, there was insufficient evidence on file that staff had been consistently documenting and monitoring residents' progress on goals set. This gap in documentation hindered the inspector's ability to assess whether goals had been achieved or what progress had been made. Consequently, it was recommended that improvements be made in documentation practices to ensure that goals were clearly tracked.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that there were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. For example, two positive behaviour support plans and one psychology support plan reviewed by inspector were detailed, comprehensive, and developed by an appropriately qualified person. In addition, each plan included antecedent events, proactive and preventive strategies in order to reduce the risk of behaviours that challenge from occurring.

Staff spoken with were knowledgeable of support plans in place and the inspector observed positive communications and interactions throughout the inspection between residents and staff. Furthermore, systems were in place to ensure regular monitoring of the approach taken to behavioural support, and staff did not engage in practices that may constitute institutional abuse.

Residents were connected with members of the provider's multidisciplinary team, including a psychologist and a behaviour specialist, who actively monitored incidents and collected data in order to inform interventions and provide positive behaviour supports to residents.

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 eight restrictive practises were notified, encompassing environmental, and mechanical 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).

Judgment: Compliant

Regulation 8: Protection

This inspection found evidence that there was inadequate and ineffective arrangements in place to protect residents from all forms of abuse. For instance, over the past 12 months, a total of 64 safeguarding concerns were reported to the Chief Inspector. On the day of this inspection, 28 safeguarding concerns remained open as the National Safeguarding Office determined there was reasonable grounds for concern.

The inspector conducted a comprehensive review of a sample of safeguarding concerns within the designated centre. A number of formal safeguarding plans reviewed by the inspector referred to the provider looking at options for alternative spaces for residents. However, on the day of this inspection, the provider had not established a specific time-bound plan to address this. This lack of clear action left ongoing compatibility and safeguarding concerns unaddressed, ultimately putting the wellbeing of vulnerable adults at risk.

Furthermore, the formal safeguarding plans suggested that residents should be encouraged to relocate to another area when other residents are distressed. However, given the limited space in the designated centre, this option was not feasible. The inspector observed and read documentation that evidenced that loud vocalisations throughout the day and into the evening could lead to prolonged episodes of self injurious behaviours among residents. Despite this, the inspector found no evidence of a clear, effective plan to address these challenges. This raised concerns about the designated centre's ability to safeguard residents from harm or

abuse, highlighting the need for a thorough and comprehensive review by the provider.

Judgment: Not compliant

Regulation 9: Residents' rights

This inspection found that some residents lived in a home that was not in line with their assessed needs. Furthermore, and as discussed throughout this report, ongoing compatibility and safeguarding concerns had not been mitigated and were adversely impacting on the residents' quality of life, and their wellbeing.

Evidence highlighted that residents' right to a safe and supportive living environment was compromised. Specific instances included continued loud vocalisations within the designated centre which negatively impacted on residents which could result in frequent episodes of self-injurious behaviours. The inspector noted that during the months between July and September 2025, there was a total of 85 incidents of behaviours that challenge documented. Other incidents included one resident trying to access the bathroom when another resident was receiving personal care. This negatively impacted the resident causing them to engage in self injurious behaviours and required staff to lock doors in order to maintain the safety and dignity of the resident. A further incident reviewed by the inspector occurred in April 2025, which stated that the kitchen door needed to be locked "for residents' safety".

A review of three residents' positive behaviour and psychology support plans evidenced that residents were living in a home which did not meet their assessed needs. Specifically, one resident's psychology support plan stated "antecedents for upsets and loud vocalisations are usually related to environmental commotions or noises that unsettle" the resident. If other people shout they will become "anxious or annoyed". It further reported that the resident may engage in loud vocalisations or "will hit or scratch face" in response.

Another resident's positive behaviour support plan reported that resident liked "quiet environments", and their wellbeing can be impacted by environments with "high sensory load". Given the frequent loud vocalisations, and limited space the designated centre was not meeting the resident's assessed needs and was infringing on their right to live in a home where they felt safe and secure.

Furthermore, one resident's positive behaviour support plan documented that they benefited from a "low arousal approach", and "reducing noise levels where possible". The use of ear defenders and headphones were introduced as a means of mitigating negative impact. However, the inspector observed evidence through incident review and documentation that this approach did not positively impact the resident and they were still engaging in self injurious behaviours as a result.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for Donabate Residential OSV-0003597

Inspection ID: MON-0044772

Date of inspection: 02/12/2025

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Person In Charge has reviewed and amended the rosters management process to ensure that full names of all relief and agency staff, along with the name of the relevant agency, are consistently recorded on duty rosters. Date: Complete (03/12/2025)	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person In Charge completed a local audit of staff training records based on training certificates submitted by staff. This audit identified additional completed training that had not been captured in the training department audit and resulted in an increase in overall training compliance levels. In addition, since the HIQA inspection, a number of staff have completed previously out of date training. o Safeguarding – all were completed by 22/01/26 o Positive Behaviour supports – 1 staff has completed refresher training -3 are scheduled for refresher training 2 on 11/3/26 & 1 on 12/3/26. 3 staff on waitlist for next upcoming initial training in April 2026. o Fire Safety Training – 2 staff require training and have been allocated protected time on 22/1/26 on 23/1/26 o Manual Handling – 7 staff are booked in for training in Q1 of 2026. 1 on 3/2/26. 2 on 11/2/26. 2 on 3/3/26. 2 10/3/26. o FEDS – 3 staff have completed and one outstanding is scheduled protected time to complete on 24/1/2026. • The PIC has developed a training tracker for all staff to record, track, and monitor their mandatory training to ensure it remains up to date. A copy of this tracker will be	

maintained in the designated center's training folder.
Date: 31/01/2026

• Staff training and compliance will be reviewed and discussed as part of the quarterly supervision meetings to ensure individual training needs are identified and addressed in a timely manner.
Date: 31/03/2026 Ongoing

• Training has been added as a fixed agenda item at staff meetings. Date: 31/01/2026 Ongoing

• All in-person training will be scheduled with the Training Department once relevant dates become available in the new year. Date: 31/03/2026

• A roster review has been scheduled to explore if there is scope to increase protected management time for the PIC within the current whole-time equivalent to support effective staff supervision. In addition, a formal supervision plan schedule has been developed for 2026 and will be implemented and monitored to ensure regular supervision.
Date: 31/03/2026 Ongoing

Regulation 23: Governance and management	Not 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, 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 there is scope within the current whole time equivalent to allocate additional management hours to the PIC.
Date: 20/01/2026

• The 6 monthly audit tool will be reviewed and revised by the Quality and Safety Dept.
Date 28/02/2026

• The information identified as missing from the monthly data reports has now been reviewed and updated by the PIC.
Date: Complete (23/12/2025)

• The PIC and Service Manager will meet monthly to review the monthly data reports to ensure that all required information is accurately recorded, any gaps are addressed, and relevant matters are appropriately escalated to management where required.
Date: 31/01/2026 Ongoing

• All outstanding actions on 6 monthly audit have been completed
Date: Complete (23/12/2025)

• All outstanding actions from the previous compliance plan have now been completed. Date: Complete (23/12/2025)

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • The PIC will ensure that goal trackers are implemented and regularly updated for all residents' goals. Date 31/01/2026 Ongoing	

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Action Person Responsible Completion Date Status The Estates Dept has completed a site visit and reviewed the floor plans. Recommendation regarding the scope of works required to provide residents with access to their own space where they can spend time away from others. Director of Estates 12/01/2026 Completed MDT scheduled to plan for a transition of one resident with a long-term progressive condition to an environment that can support their assessed needs. Director of Nursing 28/02/2026 (admission) Pending Cost for recommended work to be submitted. Director of Estates 14/02/2026 Pending Three residents of the designated centre have been added to the escalation template for discussion at operational HSE meeting Director of Nursing 20/01/2026 Complete Residents' profiles are being prepared for referral to SMH Residential Approvals Committee for consideration for internal transfer should potential vacancy present. PIC and PPIM 01/02/2026 Ongoing Prepare a business case for submission to the HSE to request funding for the proposed works to the building PPIM and PIC 28/02/2026 Pending Assessment and planning meeting to reduced numbers and impact on funding with HSE Director of Access and Integration, Director of Estates, Director of Nursing via Residential Approvals Committee 20/01/2026 Pending On approval of funding, the Registered Provider will submit an application to vary registration to reduce the number of residents in the designated centre PPIM on behalf of the Registered Provider TBC Pending On approval of funding, the Registered Provider will submit an application to vary registration to reflect any changes to the floor plans PPIM on behalf of the Registered Provider TBC Pending The Statement of Purpose will be updated to reflect the revised number of residents and any room repurposing. PIC TBC Pending Meeting with MDT to plan communication supports, potential impact of a number of moves occurring simultaneously, and logistics. PPIM 31/01/2026 Pending MDT meetings will be scheduled for each resident and their family to inform them of the proposed plans Multi-disciplinary team, PIC and PPIM All meetings to be completed by 28/02/2026 Pending Commence implementation of moves within the home PPIM and PIC and staff team. 16/03/2026 Pending Completion of moves within the home PPIM and PIC and staff team.	

16/04/2026 Pending
Regulation 9: Residents' rights
Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Action Person Responsible Completion Date Status
The Estates Dept has completed a site visit and reviewed the floor plans. Recommendation regarding the scope of works required to provide residents with access to their own space where they can spend time away from others. Director of Estates 12/01/2026 Completed
MDT scheduled to plan for a transition of one resident with a long-term progressive condition to an environment that can support their assessed needs. Director of Nursing 28/02/2026 (admission) Pending
Cost for recommended work to be submitted. Director of Estates 14/02/2026 Pending
Three residents of the designated centre have been added to the escalation template for discussion at operational HSE meeting Director of Nursing 20/01/2026 Complete
Residents' profiles are being prepared for referral to SMH Residential Approvals Committee for consideration for internal transfer should potential vacancy present. PIC and PPIM 01/02/2026 Ongoing
Prepare a business case for submission to the HSE to request funding for the proposed works to the building PPIM and PIC 28/02/2026 Pending
Assessment and planning meeting to reduced numbers and impact on funding with HSE Director of Access and Integration, Director of Estates, Director of Nursing via Residential Approvals Committee 20/01/2026 Pending
On approval of funding, the Registered Provider will submit an application to vary registration to reduce the number of residents in the designated centre PPIM on behalf of the Registered Provider TBC Pending
On approval of funding, the Registered Provider will submit an application to vary registration to reflect any changes to the floor plans
PPIM on behalf of the Registered Provider TBC Pending
The Statement of Purpose will be updated to reflect the revised number of residents and any room repurposing. PIC TBC Pending
Meeting with MDT to plan communication supports, potential impact of a number of moves occurring simultaneously, and logistics. PPIM 31/01/2026 Pending
MDT meetings will be scheduled for each resident and their family to inform them of the proposed plans Multi-disciplinary team, PIC and PPIM All meetings to be completed by 28/02/2026 Pending
Commence implementation of moves within the home PPIM and PIC and staff team. 16/03/2026 Pending
Completion of moves within the home PPIM and PIC and staff team. 16/04/2026 Pending

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Actions prior to inspection:

• A compatibility assessment meeting was held on the 05/02/2025. Actions identified at that meeting was to hold individual safeguarding ICM meetings to explore the impact on

individuals, and to identify the person(s) of concern for each resident.
Date: Complete (05/02/2025)

• Follow up compatibility meeting held to review findings from ICMs. One outcome being that there was more space needed to facilitate residents to have time alone to reduce safeguarding incidence.
Date complete (07/05/2025)

• The provider conducted an assessment on the potential for an additional room to be built on to the existing home to facilitate alternative spaces as per residents safeguarding and PBS plans. Outcome from assessment was this extension would not address the safeguarding concerns due to floor plan of the building.
Date: Complete (01/09/2025)

• The Provider committed to pause new admissions to the vacant bed in the home.
Date: Complete (12/09/2025)

• The PIC identified funding to create a garden room which would provide alternative space for residents. Architect drawing, buildings quotations, and all relevant documentation for construction was gathered and provided to the estates department for review. Prior to commencement of works, it was found that due to local planning requirements that this structure would not comply with regulation. Date: Complete (21/11/2025)

Actions post inspection:

• A potential alternative home was identified for one resident and a consultation meeting held (18/11/2025). However, this ceased due to residents' medical complexities. Another ICM for this resident will be scheduled, to ensure all required supports are in place.
Date: 31/01/2026

• The PIC and PPIM will develop service user profiles and refer to the SMH Residential Approvals Committee.
Date 01/02/2026

• Support plans will be reviewed to ensure that strategies such as low arousal approaches and noise reduction are realistic within the current setting. Where these strategies cannot be consistently implemented, alternative proportionate measures (e.g. structured routines, access to quieter areas at designated times, use of individualised activity scheduling, or sensory supports) will be identified and documented.
Date: 28/02/2026 Ongoing

• Undertake a formal review of the effectiveness of sensory aids and trial alternative evidence-based interventions under MDT guidance.
Date: 31/03/2026

• Complete an immediate review of residents' assessed needs, compatibility risks, and environmental suitability; update individual risk assessments accordingly. Date: 31/01/2026

• Compatibility meetings will be scheduled monthly and attended by PIC, PPIM, Director of Nursing and Designated Officer. These meetings will remain in place until the compatibility issues within the centre are resolved.
Date: 31/01/2026

• To mitigate against further safeguarding issues and in agreement with individual residents within the centre, the PIC will offer and coordinate overnight breaks away for residents.
Date: Commencing 01/02/2026.

• Following any incident, residents will continue to be reassured and offered 1:1 support and/or clinical support where required.
Date: Ongoing

• The Provider will continue to raise the risks within the centre with HSE local safeguarding team.
Date: Ongoing

• Complete an options appraisal for environmental reconfiguration or relocation to ensure residents can access appropriate quiet, private, and low-arousal spaces. Date: 14/02/2026.

• The Provider will submit a business case to the HSE to seek appropriate funding for adapting or reconfiguring the existing building to facilitate the development of appropriate spaces to provide residents with a low-arousal environment that is consistent with their assessed need.
Date: 31/03/2026

• The Provider will escalate the risk identified within the centre at HSE IMR meetings until the compatibility issues within the centre are resolved.
Date: 31/01/2026

• Residents will be offered access to independent advocacy to support them to express their views regarding their living environment and compatibility arrangements. Where appropriate, and in line with resident's will and preferences, families or nominated decision making supports will be involved in discussions and decision- making processes.
Date: 30/06/2026

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(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.	Substantially Compliant	Yellow	03/12/2025
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.	Not Compliant	Orange	31/03/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	28/02/2026

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/03/2026
Regulation 05(6)(d)	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 take into account changes in circumstances and	Substantially Compliant	Yellow	31/01/2026

	new developments.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	16/04/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	16/04/2026