



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

Issued by the Chief Inspector

Name of designated centre:	Ferndale/Avondale
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Unannounced
Date of inspection:	27 January 2026
Centre ID:	OSV-0003598
Fieldwork ID:	MON-0045297

About the designated centre

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

Ferndale is a designated centre operated by St Michael's House located in North County Dublin. It provides community residential care for up to seven adults with disabilities. The centre comprises two houses next door to each other. Both houses are two-storey and share a common driveway and back yard. The first house comprises five bedrooms, sitting room, kitchen/dining room, utility room with laundry facilities, sun room and shared bathrooms. The second house comprises four bedrooms, sitting room, utility room, a kitchen/dining room and shared bathrooms. The centre is staffed by a person in charge and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7
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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
Tuesday 27 January 2026	09:00hrs to 17:00hrs	Kieran McCullagh	Lead

What residents told us and what inspectors observed

The purpose of this unannounced inspection was to monitor the care and welfare, and support arrangements for residents living in the centre and assess compliance with the regulations. This inspection determined that although residents were provided with high quality care and support, improvements were identified under a number of regulations inspected. Specifically, improvements were required regarding training and staff development, and personal possessions. Further improvements were necessary pertaining to directory of residents, governance and management, and protection against infection.

The inspection was completed over the course of one day and was facilitated by the person in charge who engaged with the inspector and promptly provided all requested documentation. Through careful observation, direct interactions, a thorough review of documentation, and discussions with residents, and key staff, the inspector evaluated the residents' quality of life.

The inspector did not have an opportunity to speak with the relatives of any of the residents, however a review of the provider's annual review of the quality and safety of care evidenced that they were happy with the care and support that their relatives received.

The inspector found that the centre was reflective of the aims and objectives set out in the centre's statement of purpose. The residential service aims to "maintain a healthy and safe home where everyone feels welcome", "staff respect resident's choices and decisions", and "residents develop their talents and learn new skills, which they can use in the community". The inspector found that this was a centre that ensured that residents received the care and support they required but also had a meaningful person-centred service delivered to them.

The designated centre comprised of two two-storey buildings, located in a residential suburb northside of Dublin city. House one comprised of five bedrooms, including a staff sleepover room, a sitting room, a kitchen / dining room, a sun room, a utility room, and two bathrooms. House two comprised of four bedrooms, including a staff sleepover room, a sitting room, a kitchen / dining room, a utility room, and two bathrooms.

The designated centre was registered to accommodate seven residents and the inspector had the opportunity to meet and spend time with all residents throughout the course of the inspection.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by a staff team, who was knowledgeable about the assessed needs of all residents living in the centre.

The person in charge worked full-time and had sole responsibility for the management of this designated centre. They were supported in their role by a service manager, who in turn reported to a Director of Adult Services.

The inspector carried out a walk around of the centre in the presence of a resident and the person in charge. Both homes within the designated centre were observed to be clean and tidy, and were decorated with residents' personal items such as photographs and artwork. To the rear of the designated centre was a well maintained garden area, with outdoor seating, planting, bird houses, and a gazebo for all residents to use as they so wished.

Residents' bedrooms were laid out in a way that was personal to them and included items that was of interest to them. One resident proudly showed the inspector their bedroom. They had been supported to reorganise their bedroom, and the inspector commented on the great work the resident had done. Family photographs, and pictures of the resident's favourite singer hung on their wall, and they showed the inspector some of their art work which was also displayed throughout the home.

The inspector spent time speaking with all residents throughout the course of the inspection. All residents informed the inspector that they were very happy living in their home. They had no complaints, and did not wish to change anything about their living environment. All residents led busy and active lives, and were supported to make choices and decisions about how they spent their time. Some residents attended day service programmes, while other residents were in receipt of a bespoke individualised service that best met their needs.

One resident had a keen interest in art and was very talented at completing custom diamond art projects, which were on display throughout the home. The resident had recently attended a fair in which some of the art works had been sold and monies saved were used by the resident to purchase additional art materials. The inspector observed the resident at intervals throughout the inspection completing art projects in the living room of the home.

Another resident had a keen interest in community activities, and attending concerts and events. The inspector saw evidence that the resident was supported to purchase tickets to their preferred events, and were supported by the staff team to attend these on a regular basis.

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 and supportive rapport with the staff team. The designated centre itself presented as a calm, relaxed environment, free from any sense of restriction.

The person in charge emphasised the high standard of care provided to both residents, expressing no concerns regarding their wellbeing. They highlighted the importance of building strong connections with the residents and setting meaningful goals to enhance their quality of life. A review of the residents' person-centred plans revealed that they were actively working on goals that held personal significance.

The inspector noted that staff members on duty were very knowledgeable of residents' needs, and the supports in place to meet those needs. Staff were aware of each resident's likes and dislikes and told the inspector they really enjoyed working in the centre and were happy with levels of support they received from management.

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 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 this report presents the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Residents residing in this designated centre had a good quality of life, and were supported by a caring and knowledgeable staff team. However, improvements were required regarding training and staff development.

The provider had implemented management systems to ensure that the service provided to residents was safe, consistent, and appropriate to their assessed needs.

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.

Appropriate training is fundamental in supporting staff to effectively and appropriately support all residents. The provider and person in charge had not ensured that all staff had up-to-date mandatory training in critical areas such as positive behavioural supports. Furthermore, some staff had not completed service specific training to enable them to provide safe and appropriate care to residents.

Moreover, staff members did not receive consistent, formal supervision as per the provider's established policy.

Improvements were required to ensure the provider maintained an accurate and up-to-date resident directory for all residents living in the designated centre.

Improvements were required to ensure the provider had suitable oversight of the centre and that effective governance arrangements were in place to ensure the service was safely and effectively managed. Specifically, enhancements to monthly data reports, residents' finance audits, and the provider's six monthly unannounced visit reports were necessary. The provider had completed an annual report of the quality and safety of care and support in the designated centre for 2024, which included consultation with all residents and their families, and representatives.

The registered provider had prepared a written statement of purpose that contained the information set out in Schedule 1. The statement of purpose clearly described what the service does, who the service is for and information about how and where the service is delivered.

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

The 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. Since the previous inspection, enhancements had been implemented to the staffing arrangements to include the addition of a waking night staff in line with one resident's assessed changing needs.

The staff was comprised of the person in charge and social care workers. The inspector examined the planned and actual staff rosters for September and October 2025. 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. The inspector noted that the staff team were appropriately qualified, and dedicated to delivering care that upheld residents' rights and ensured their safety.

The provider was actively working to maintain continuity of care for residents by utilising the core staff team, and a small panel of regular relief staff to back fill any vacant shifts. This approach ensured that, despite any staffing vacancies, and both planned and unplanned absences, residents continued to receive care from skilled staff who were familiar with their individual needs and preferences.

During the inspection, the inspector spoke with five staff members on duty and the person in charge, 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.

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

- Four staff required refresher training in positive behavioural supports
- Three staff required in person emergency first aid training
- Six staff required in person manual handling training
- Two staff required food safety training
- Two staff required feeding, eating, drinking, and swallowing (FEDS) training.

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

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. However, following a review of the supervision schedule it was evident that staff were not in receipt of supervision as per the provider's policy.

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 19: Directory of residents

Improvements were required to ensure the provider maintained an accurate and up-to-date resident directory for all residents living in the designated centre.

The inspector reviewed the directory of residents, and found that information as set out under Schedule 3 had not been recorded or maintained for two residents living in the designated centre. This required review and improvement to ensure ongoing accuracy.

The inspector confirmed that all information pertaining to the other five residents met the required standards as set out in Schedule 3. For instance, the name, address, date of birth, sex, and marital status of each resident, the name, address and telephone number of each resident's next of kin or representative, and the name, address and telephone number of these resident's general practitioner (GP) was documented in line with regulatory requirements.

Judgment: Substantially 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 effectively managed.

Clear lines of accountability were established at individual, team, and organisational levels, ensuring that all staff were aware of their roles, responsibilities, and the appropriate reporting procedures.

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

In addition to the annual review of the quality and safety of care, a number of local audits had been conducted, including those on infection prevention and control, health and safety, residents' finances, and medication. However, the inspector noted that improvements were required. For instance, the person in charge was required

to complete and submit local audits on a monthly basis to their service manager. However, upon review, the inspector found that these audits had not been completed since September 2025.

Additionally, enhancements to residents' finance audits and the provider's six monthly unannounced visit reports were necessary. For instance, residents and staff were not consulted with as part of the provider's most recent six monthly unannounced report, and discrepancies and inaccuracies relating to residents' finances was not recorded, and did not have an associated action for improvement. This required consideration and 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

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

The statement of purpose was accessible to the inspector during the inspection and was also made available to the residents, and their representatives in a format that suited their communication needs and preferences.

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.

Judgment: Compliant

Regulation 34: Complaints procedure

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

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

Residents spoken with told the inspector that they were happy, and had no complaints. The provider's complaints and incident manager had recently completed a complaints audit in December 2025. This was reviewed by the inspector, and it found that there were appropriate procedures in place for dealing with and managing complaints, and that all residents had knowledge of how to raise concerns, and how to make a complaint.

Judgment: Compliant

Quality and safety

This section of the report provides an overview of the quality and safety of the service provided to the residents living in the designated centre. Overall, the findings of this inspection were that the residents reported that they were happy, felt safe, and liked living in their home. They were making choices and decisions about how, and where they spent their time. However, improvements were required to ensure that all residents' finances were effectively audited, and managed in line with the provider's established policy. Additional enhancements were also required regarding protection against infection.

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

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

The provider had implemented a range of infection prevention and control measures. There was a policy available that was reviewed at planned intervals. This policy clearly outlined the roles and responsibilities of staff members and gave clear guidance with regard to the management of specific infection control risks. The policy also guided comprehensive cleaning and monitoring of housekeeping in the centre, and these practices were observed on the day of this inspection. However, improvements were required regarding the procedures for the ongoing and reinforcement of effective infection prevention and control practices within the designated centre.

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 in the designated centre. There was documentary evidence of servicing of equipment in line with the requirements of the regulations. The residents' personal emergency evacuation plans were reviewed regularly to ensure their specific support needs were met.

The person in charge had ensured that residents' care needs had been assessed to inform the development of personal plans. The inspector reviewed a sample of assessments and plans, including plans on intimate care, positive behaviour support, communication, and healthcare. They were found to be up to date, multidisciplinary team informed, and readily available to guide staff practice.

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

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 12: Personal possessions

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

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

The inspector completed a thorough review of two residents' expenditure records over the course of 2025. For example, the inspector reviewed one resident's expenditure records for the month of September 2025, and one resident's expenditure records for the month of October 2025. During this process, the inspector noted a number of discrepancies and inaccuracies throughout the reviewed periods. Specifically, a number of transactions lacked valid receipts, and a number of bank withdrawals were not properly documented with their corresponding purposes as per protocols set out in the provider's policy.

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

Judgment: Not compliant

Regulation 17: Premises

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

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

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

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

Judgment: Compliant

Regulation 27: Protection against infection

The provider had prepared written policies and procedures on infection, prevention and control (IPC) matters which were readily available for staff to refer to. However, improvements were required regarding the procedures for the ongoing and

reinforcement of effective infection prevention and control practices within the designated centre.

Improvements were necessary regarding refrigerator temperature monitoring, and the labelling of all opened food items. For instance, the inspector observed that across the month of January 2026 refrigerator temperature checks were not being completed and recorded on a daily basis. It was also observed that food items were not being labelled correctly once opened, which increased the risk of contamination and spoilage. These checks and protocols are a fundamental component of effective infection prevention and control and required review by the person in charge.

Additionally, during the walk around of the designated centre the inspector observed that a leather chair located in one resident's bedroom, and another chair in the living room was badly worn and torn. This prevented staff from carrying out proper infection prevention and control cleaning duties.

Comprehensive cleaning schedules were in place, and the inspector noted that cleaning duties were being routinely completed by all staff working in the designated centre. These tasks were essential in promoting strong infection prevention and control measures, and ensured a clean and safe environment for all residents, visitors, and staff alike.

All staff received appropriate training and regular updates in line with best practice guidance. Staff spoken to were knowledgeable about how to reduce the risk of infection and understood the procedures to follow in the event of an outbreak. For example, staff members were familiar with the provider's protocols pertaining to the management of laundry and linen. Additionally, the inspector observed that the necessary equipment (alginate bags) was in place, and readily accessible to effectively manage any potential outbreaks, ensuring a prompt and appropriate response if needed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had taken appropriate steps to mitigate the risk of fire by implementing effective fire prevention and oversight measures. During this inspection, the inspector observed that both homes were equipped with fire and smoke detection systems, emergency lighting, and firefighting equipment.

A review of maintenance records confirmed that these systems and equipment were subject to regular checks by staff, and inspections and servicing by a specialist fire safety company.

The inspector noted that the fire panels were addressable and easily accessible in the entrance hallways of both homes. Additionally, information pertaining to fire zones were readily available and accessible to the staff team in the event of an

emergency. It was observed that all fire doors, including bedroom doors, closed properly when the fire alarm was activated. Furthermore, all fire exits were equipped with thumb lock mechanisms, which ensured prompt evacuation in the event of an emergency.

The provider had implemented comprehensive measures to ensure that each resident was aware of fire safety procedures. For instance, the inspector reviewed the personal evacuation plans of all residents living in the designated centre. Each plan outlined the specific support required to assist residents during an evacuation, both during the day and at night.

The 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 daytime and nighttime conditions.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed three 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 positive behaviour support, communication, general healthcare, rights, feeding, eating, drinking, swallowing (FEDS), and money management.

All residents were actively engaged in the person centred planning process, and the inspector saw evidence that residents had participated and engaged in "My Life Meetings" throughout 2025. During these meetings, residents set meaningful goals they aimed to achieve. Examples of 2025 goals set included visit London to see a show, attend weekly art class, weekly trip for a hot towel shave, cook dinner on a weekly basis, work experience, and gardening activities. The inspector observed photographs of residents participating in their chosen goals and how they celebrated were included in their personal plan.

Staff spoken with demonstrated full awareness of residents' personal plans, and the care support plans that were in place to empower the residents to live as independently as they possibly could.

Judgment: 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, three positive behaviour support plans reviewed by the 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 members were knowledgeable about support plans in place, and the inspector observed positive communication and interactions between residents and staff throughout the inspection. Additionally, systems were in place to regularly monitor the behavioural support approach.

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.

There were two restrictive practices used within the designated centre which included environmental and physical restraints. The inspector completed a thorough review of these and found they were the least restrictive possible and used for the least duration possible. 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

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	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Ferndale/Avondale OSV-0003598

Inspection ID: MON-0045297

Date of inspection: 27/01/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: <ul style="list-style-type: none">• The training matrix has been reviewed and updated to reflect completed training• All staff have been booked for outstanding training, and all outstanding training will be completed by 30.04.2026.• Service Manager and PIC met with the team on 10.02.2026 to discuss staff training. A local training officer has been assigned by the PIC. This staff will monitor training compliance and manage training bookings.• Some supervisions have been completed to date, and all staff will have supervision for Quarter 1 completed by 31.03.2026.• 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 every management meeting.	
Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:

- The Service Manager and PIC met with the team on 10.02.2026 to discuss the importance of maintaining a Directory of Residents for all residents.
- All residents have an updated Directory of Residency template in their folder
- Director of Resident will be completed for all residents when they spend a night out of the centre
- All staff are responsible for completing the template as part of their daily reports' duties. Keyworkers will monitor the Directory of Residents templates to ensure they are being completed as required when completing monthly reports.

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Regulation 23: Governance and management

Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- The provider will continue to complete six monthly audits and ensure consultation with residents and staff is documented.
- The provider will continue to complete management meetings with the PIC with an enhanced focus on the governance and management of the centre.
- Monthly Data report for January 2026 is now completed. PIC to complete monthly data reports and submit to the service manager monthly for discussion at Service Manager/PIC management meetings.
- The PIC and Service Manager will review team supervision meetings at management meetings and discuss staff performance regarding personal plans and personal development.
- Service Manager and PIC met with the team on 10.02.2026 to discuss governance and management improvements and areas of responsibility were delegated as appropriate.
- Monthly Finances review audit template to include identified discrepancies; all discrepancies to be escalated as per policy.
- Service Managers' six monthly finance audits to document discrepancies and actions as identified.
- The provider's six-monthly audit is currently under review by the providers Director of Quality Safety and Risk, and a new template is expected to be rolled out in 2026. The review is currently at the consultation stage, but changes have been identified to improve the overall effectiveness of the audit tool.

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Regulation 12: Personal possessions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 12: Personal possessions:</p> <ul style="list-style-type: none"> • Service Users Monies Policy is currently under review and will be published before 24.02.2026 • Service User Holiday Policy is currently under review and will be published before 24.02.2026. • The Service Manager and PIC met with the team on 10.02.2026 to discuss required improvements regarding effective oversight, recording and auditing of all residents' finances. • All residents now have an updated itemised list of possessions and key workers will update this list on monthly basis or as when required. • Financial support plans have been reviewed to reflect residents' will and preference regarding how they choose to manage their finances. Enhanced financial recording has been implemented to support residents to safely manage their finances, including documentation of residents' consent around holiday expenses and those who choose not to bring purchase receipts back to the centre. • Monthly Finances review audit template to include identified discrepancies with all discrepancies to be escalated as per policy. • Service Managers Six monthly finance audits to document discrepancies and actions as identified. • The provider's six-monthly audit (to include finances) is currently under review by the providers Director of Quality Safety and Risk, and a new template is expected to be rolled out in 2026. The review is currently at the consultation stage, but changes have been identified to improve the overall effectiveness of the audit tool. <p>]</p>	
Regulation 27: Protection against infection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <ul style="list-style-type: none"> • The Service Manager and PIC met with the team on 10.02.2026 to discuss the ongoing reinforcement of effective infection prevention and control practices within the designated centre and food hygiene practices. • Daily IPC logs such as refrigerator logs and Food hygiene practices have been relocated to prominent place in kitchen to remind staff to complete. They are also included in the checklist of daily duties. • The Local IPC officer will audit these logs on a weekly basis to ensure they are being completed as per policy. • Referrals submitted to OT on 06.10.2025 and 17.02.2026 for the replacement of worn and torn personal furniture items. PIC to follow up on these referrals by 31.03.2026. <p>]</p>	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	20/02/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/04/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/03/2026

Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	20/02/2026
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	20/02/2026
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.	Substantially Compliant	Yellow	20/02/2026
Regulation 27	The registered provider shall ensure that residents who may	Substantially Compliant	Yellow	31/05/2026

	be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
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