



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

Issued by the Chief Inspector

Name of designated centre:	St Michael's House Ballygall
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Unannounced
Date of inspection:	17 February 2026
Centre ID:	OSV-0005706
Fieldwork ID:	MON-0048811

About the designated centre

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

St Michael's House Ballygall designated centre is a residential service that can support three young adults with an intellectual disability at any given time. The service can support both males and females. The centre is located in County Dublin and is a two story home which has been renovated and extended to meet the residents' autism support needs. The house has its own transport bus and is also located in close proximity to public transport and a wide variety of social, recreational, educational and training facilities. Each resident has their own bedroom and bathroom. There is a shared kitchen and dining room, three living rooms, one of which is upstairs. There is a large back garden with separate areas including a zip line, circular cycle track and other equipment for play. The house is managed by a person in charge and is staffed by a mix of 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:	3
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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 17 February 2026	10:15hrs to 16:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This was an unannounced inspection to monitor the provider's progress in coming into compliance with the Regulations.

A high level of non-compliance was found on the last inspection of the centre in October 2025 with evidence of negative impact on the residents' safety and well-being. The provider was invited to attend an escalation meeting with the Office of the Chief Inspector due to the poor findings from the previous inspection. The provider submitted an action plan detailing how they intended to ensure the safety of the service and bring the centre back into compliance. This inspection reviewed the implementation of the provider's action plan.

Overall, this inspection found that the provider had enhanced their oversight of the centre and had established effective risk management systems. Significant improvements were identified in risk management and the quality of service for the residents had been enhanced. There remained one deficit in that the centre was not designed or laid out in a manner suitable to meet the needs of the residents. At the time of the inspection, the provider was exploring options and was developing a plan to address this issue. This will be discussed further in the quality and safety section of the report.

The designated centre is located in North Dublin and is home to three adults with intellectual disabilities and autism. The inspector saw, on arrival, that works had been completed to the premises of the centre. Outside, in a courtyard used by one of the residents, a colourful mural had been created. The mural was designed around the resident's favourite poem and was bright and cheerful. Inside, the inspector saw that the house was clean and well-maintained. Damaged flooring on the stairs had been replaced and painting to internal walls had been completed. The inspector was told that the residents had chosen the colour of the paint for their private spaces and there were plans to further enhance these spaces by creating murals inside the house.

Two of the residents were in the centre when the inspector arrived and one of the residents had left to go to day service. The inspector was introduced to two day service staff who had been deployed to the centre to support the residents with day service activities. The inspector was told that a building had been identified as suitable to provide individualised day services to these two residents but it required works. In the meantime, day service staff were available in the centre five days a week to get to know the residents and to facilitate day service activities. The inspector was told that these day service staff would move to the day services building with the residents when it was ready, thereby ensuring continuity of care for the residents.

The inspector had an opportunity to speak with the day service leader who was in the centre on the day of inspection. They showed the inspector the residents' individualised timetables and described how residents were accessing increased community activities and exploring other activities relating to their interests. For example, one resident was accessing a hydrotherapy bath for water play in another of the provider's facilities. This resident was also being supported to access parks and play facilities. The inspector saw photographs and videos of the resident using swings and trampolines and saw that they appeared happy and relaxed.

Good communication between the staff team was observed. For example, staff members communicated with each other about the plans to support a resident to go out for a community activity. Staff members were seen checking with each other to ensure that the resident had all the items they required. They communicated to the inspector the plan, as detailed in the resident's behaviour support plan, to assist them to safely get on the bus.

The inspector spoke with three front-line staff in detail over the course of the day. The staff members told the inspector that they had seen great improvements in the service since the last inspection. They described how they were being supported by the person in charge in their roles. Staff members said that the person in charge listened to them and provided clear direction in respect of meeting residents' needs. The inspector was told that staff members had clear responsibilities each day and that these were demonstrated through a colour coded system on the roster.

Staff members told inspectors that the residents' care plans and risk assessments had been updated and that all staff were informed of them. The impact of this was that staff members were providing consistent care to residents. This had resulted in a reduction in incidents of concern and an enhanced quality of life for the residents. In particular, staff members felt that the access to day service supports was very beneficial to the residents. One staff member told the inspector that they aimed to support the residents to live the life that they wanted to and that they now felt that they were realising this goal.

Staff members told the inspector that they could see that residents were happier in their home. They spoke of residents smiling more and interacting with staff members. Staff members said that residents have schedules and plans now and that they are informed of these plans through visual supports.

The inspector met with one of the residents while they were sitting on the bus, before going out for a walk. The inspector greeted the resident and the resident made eye contact. They appeared comfortable and relaxed and were seen to have their preferred items with them to bring on the walk.

A second resident was at home for the morning. The inspector did not interact directly with this resident due to known risks and so as not to disrupt their typical routine. The inspector heard the resident vocalising and saw staff members responding to them. Staff members were seen to offer the resident their preferred activities, in line with their schedule throughout the day. These included listening to

music, playing in the garden, watching television and later, going out on the bus for a drive.

The inspector saw that the staff and resident interactions were positive and encouraging. Staff members were observed engaging the resident in play in the garden and providing praise and encouragement. The inspector saw that there were measures implemented to protect this resident's dignity should they engage in behaviours which compromised this, as was identified as a risk on the previous inspection.

A walk around of each of the residents' private living spaces was completed when residents had left the centre. This was done so as to avoid risk of an incident of concern occurring. The inspector saw that works had been completed to residents' bedrooms and living spaces including painting and removing damaged furniture. There remained some improvements to bathrooms and to one resident's mattress. This will be discussed further in the quality and safety section of the report. Staff members showed the inspector additional improvements that had been made including, for example, introducing visual schedules and removing some of the restrictive practices such as light switch restrictions.

Overall, the inspector saw that the provider had made significant enhancements to the quality and safety of care provided for in the centre. Residents were now being supported by a suitably trained and well-supported staff team who were striving to uphold residents' rights and to ensure that they had a good quality of life. There were effective systems in place to manage risks and this was ensuring the safety of care for the residents.

The next two sections of the report will describe the governance and management arrangements and how effective these were in ensuring the quality and safety of care.

Capacity and capability

This section of the report describes the leadership and management arrangements of the centre. This inspection found that the provider had enhanced the management systems and that the residents were in receipt of care and support from a consistent and suitably trained staff team. This was having a positive impact on the quality of life of the residents who lived in the centre.

The designated centre had defined management arrangements which set out lines of authority and accountability. Staff members spoken with, including front-line staff and leaders, were informed of their specific roles and responsibilities. Staff members were aware of how to escalate risks through the management systems and reported that the managers were receptive, listening to and acting on concerns raised. Staff

members were supported to effectively exercise their personal, professional and collective accountability for the provision of safe and effective care.

Leadership was demonstrated by the managers of the centre who were committed to continuing to improve the quality of the service for the residents. A service improvement plan had been implemented subsequent to the last inspection of the centre. This had already brought about substantial improvements in the service quality. The provider was continuing to review this plan monthly and was in the process of establishing an action plan regarding the unsuitable layout of the premises at the time of inspection.

The staffing complement of the centre had been enhanced by the addition of day service staff. The day service staff were working with the front-line staff in order to ensure that residents were in receipt of an individualised service which was providing them with meaningful opportunities for social activation.

All staff members had access to a training and development programme and there was a high level of compliance across mandatory and refresher training. This ensured that staff members maintained their competence in all relevant areas.

Regulation 16: Training and staff development

There had been enhancements to the support and supervision of staff working in the centre. Staff members told the inspector that they felt listened to and well-supported in their roles. They told the inspector that they understood their roles and responsibilities and that they were supervised and performance managed. The inspector saw that there was a supervision log in place which documented that supervision would be provided in line with the provider's policy.

The inspector reviewed the records of staff meetings from December 2025 and January 2026 and saw that these were facilitated by the person in charge and other relevant stakeholders from the provider including, for example, members of the multidisciplinary team. This afforded the staff team the opportunity to seek guidance and clarity on policies, procedures, risk assessments and care plans.

A training matrix was maintained which showed that all staff members were up to date with key training in areas including managing behaviour that is challenging, safeguarding, infection prevention and control and safe administration of medicines. All staff members had also completed in-person training in a human rights based approach to care. It was evident, from speaking with staff, that they were using this training to ensure that residents' rights were being promoted.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management systems in place in the centre with allocated roles and responsibilities for each staff member and manager. Staff members told the inspector that the roster for the centre was now colour-coded and clearly detailed each staff member's allocated responsibilities. For example, the inspector was told that the shift leader for the day was colour-coded purple. Staff members were informed of the management arrangements. They understood how to raise concerns through the management systems. Staff members said that they found the management team responsive and that they felt listened to.

The designated centre was effectively resourced to ensure the delivery of care in accordance with the statement of purpose. Day service staff had been deployed to the centre to enhance the staffing arrangements. This was effective in enhancing the quality of care and ensuring that residents were being provided with personally meaningful and engaging activities throughout the day. An administration staff was also working in the service at the time of inspection and was assisting the person in charge with reviewing paperwork and ensuring that this was up to date and in line with the requirements of the Regulations.

There was increased oversight from the senior managers. A service manager attended the centre on a weekly basis and had regular meetings with the person in charge in order to ensure ongoing implementation of the service's quality improvement plan. A service improvement team met monthly. Senior managers from the provider including the service director and the head of quality, health and safety attended monthly service improvement team meetings. The action plan was reviewed at these meetings and it was evident that actions were being completed in order to enhance the quality and safety of care.

The service improvement team was in the process of exploring options to ensure that residents' assessed needs were being met in the centre. It was known that the centre was not designed or laid out in a manner suitable to meet the residents' needs and that the layout of the centre posed risks to residents and to the staff team. This will be discussed further under Regulations 5 and 26. While potential options were being explored, there was not yet a defined and timebound action detailed on the service improvement plan which would ensure that the service was safe and suitable to meet the residents' needs.

Judgment: Substantially compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents who lived there. Overall, this inspection found that the management team had implemented their actions as detailed in their compliance plan response, subsequent to the last inspection of the service. These actions were effective in ensuring that residents were in receipt of individualised care and support and that this was provided for in a safer environment and by a suitably trained staff team.

However, due to the layout of the centre and known risks due to residents' needs, there remained a significant number of restrictive practices and high or red-rated risks. While the inspector saw that there was enhanced oversight of risk in the centre, ultimately these risks could not be reduced until the residents were living in a more suitable premises. The provider was engaging other professionals including the multidisciplinary team and architects at the time of inspection in order to draw up a formal plan to address this deficit.

Residents had a comprehensive assessment of their health and social care needs which informed personal plans. These personal plans detailed the supports required to maximise residents' personal development and quality of life in line with their preferences. The plan was informed by multidisciplinary professionals. There was clear guidance provided through care plans for staff in how to support residents' communication, intimate care and behaviour support needs.

The designated centre was homely, clean and generally well-maintained. Each resident had their own private space which was decorated in line with their wishes. There were sufficient bathrooms for the number of residents and food preparation areas were clean and well-maintained. There were some minor improvements required to aspects of the premises to ensure effective infection prevention and control (IPC) systems.

There was an established risk management framework in the centre. Risks had been identified, assessed and control measures to manage risks were detailed. Staff members were informed of the risk assessments and of the control measures. They were knowledgeable of the protocols and procedures to ensure the safety of the residents.

There remained a high number of environmental restrictive practices in the centre. The provider had enhanced their oversight of these and now had systems in place to ensure that they could be reviewed on an ongoing basis. Some of the restrictive practices had been reduced or eliminated since the last inspection; however, due to the layout of the centre and the risks it posed in line with residents' needs, there remained a need for many restrictive practices. The layout of the centre was not effective in ensuring that residents were living in as restraint-free an environment as possible which was upholding their human rights to freedom and control in their everyday routines.

Regulation 10: Communication

The inspector was told that the designated centre now had access to a speech and language therapist who was providing support and guidance to the staff team in meeting the residents' communication needs. Staff members showed the inspector the visual schedules that were in place and described how they used these to offer the residents choices and to keep them informed of their plans.

The inspector saw, on reviewing two residents' files, that they contained up to date communication passports and communication care plans. These documents detailed how staff members could best support residents' communication. The inspector saw staff members implementing these strategies throughout the day. The inspector saw staff members responding to residents' vocalisations and words and providing choices and activities as requested by residents. Staff members were seen consulting with residents about the routine and keeping them informed of the plans.

Judgment: Compliant

Regulation 17: Premises

Upkeep had been completed to the premises and it was generally seen to be clean and well-maintained. Each resident had access to their own bedroom, living room and bathroom. The residents' living spaces had been painted and were bright and fresh. Residents had access to their preferred activities including sensory toys and music and televisions. There remained some minor upkeep to parts of the premises, including:

- a small section of floor covering was missing in one living room. The inspector was told that this was due to be repaired the day after the inspection.
- one of the bathrooms required cleaning and repair to the grouting and to the architraves
- one resident required a new mattress, as the protective covering was ripped and posed an infection prevention and control (IPC) risk

The communal areas of the centre provided a kitchen, dining room, utility and garden. These parts of the centre were clean and well-maintained. However, the utility room was also used as an office and a medication room.

The inspector saw, and was told, that there was considerable pressure on the centre's utility room as, due to IPC risks, the single washing machine for the centre was in almost constant use throughout the day. The inspector was told that it could be difficult, at times, to keep up with the washing and drying, particularly of larger items such as duvets and pillows. Staff told the inspector that occasionally they used a dryer in a local garage as this was bigger and could dry these items more effectively but that these were costly and so were not used on a regular basis.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There had been a comprehensive review of the risk management systems of the centre subsequent to the last inspection. The inspector saw that there was now a risk register in place which detailed the risks present in the service and the control measures to mitigate against these. Detailed risk assessments were implemented for both individual and service specific risks.

The inspector found, in speaking with staff, that they were informed of the risk assessments and the protocols to reduce risks. For example, one resident presented with a risk of ingesting inedible items (PICA). There was a risk assessment in place for this. Staff members knew where to locate the risk assessment and described the control measures in place, which included checking the resident's living space at specific times throughout the day and documenting this in the resident's daily notes. The inspector checked the resident's daily notes and saw that this practice was being completed consistently by the staff team.

There were consistent protocols to review adverse incidents. Adverse incidents were documented and were reviewed by the person in charge and a member of the provider's multidisciplinary team on a monthly basis. This ensured that risk assessments and care plans could be updated regularly in light of adverse incidents.

There remained six high (or red-rated) risks in the centre and two of these related to the layout of the centre and behaviours that challenge. The layout of the centre posed risks to the staff teams' ability to safely support residents at certain times. There were a number of control measures being implemented in respect of this and the provider, as discussed under Regulation 23, was exploring options to improve the layout of the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed two of the residents' files which contained their individual assessments and care plans. These had been updated since the last inspection and now reflected the residents' needs as adults. The assessments and care plans were informed by the multidisciplinary team and reflected residents' choices and preferences in respect of their care. Staff members spoken with were informed of these and were clearly implementing care plans in the delivery of support. This is described further under the subsequent regulations.

However, while improvements had been made to the residents' assessments and care plans, the designated centre remained unsuitable to meet the assessed needs of the residents. The layout of the centre, along with known behaviour risks, posed a risk to the safety of residents and staff. These risks were reflected on the centre's risk register through a number of high (or red-rated) risks which included the risk of residents having a negative experience due to the living arrangements and the risk of physical harm.

The provider had commissioned a service improvement team who, at the time of inspection, were exploring multiple options in order to address the unsatisfactory layout of the centre. Additionally, multidisciplinary assessments were ongoing in order to better inform what an ideal living environment would like for the three residents. While this work was ongoing, it was evident that the centre remained unsuitable to meet the needs of the residents and there was not yet an agreed plan on how the provider would address this

Judgment: Not compliant

Regulation 7: Positive behavioural support

All staff working in this centre were up to date with training in positive behaviour support and behaviour intervention techniques (TIPS). The inspector saw, on reviewing two residents' files, that they each had an up-to-date and comprehensive positive behaviour support plan. This plan was completed by a suitable multidisciplinary professional. It detailed the residents' communication style, behaviours and the supervision requirements to ensure their safety. The plan also described restrictive practices which were implemented and gave a rationale for these.

The inspector saw that staff members were engaging with residents in a manner which was in line with their behaviour support plan. For example, one resident's plan detailed that they required a calm and well-planned transition when going on the bus. The inspector saw that this was planned in a safe manner and that the staff team communicated with each other to ensure this.

There was enhanced oversight of the restrictive practices implemented in the centre. These were recorded in a restrictive practices log for each resident. All restrictive practices had been referred to the provider's rights monitoring committee for review and approval. The inspector saw that this was effective in ensuring that restrictive practices were being monitored and that they were being reduced or eliminated when no longer required. Since the last inspection, a number of restrictive practices had been reduce or eliminated including, for example, light switch restrictors and nightly checks. There remained a high number of restrictive practices required due to the layout of the centre, as discussed under Regulations 5 and 9.

Judgment: Compliant

Regulation 8: Protection

Staff members in this centre had all received and were up-to-date with required safeguarding training including Safeguarding Vulnerable Adults and Children First. Residents' files contained comprehensive care plans and risk assessments to guide staff in ensuring that residents' care needs were being met in a manner which upheld their privacy and dignity. The inspector saw that staff members implemented the control measures to protect residents' dignity. For example, staff members took measures to protect a resident's dignity in the garden should they engage in a known behaviour which could compromise them.

Residents' files also contained intimate care plans to guide staff in meeting residents' needs in a person centred manner. These care plans clearly detailed residents' preferences; for example, one resident's care plan described how they liked their shower to be the last activity in their daily routine. Another plan detailed a resident's preferences for specific toothpastes.

Judgment: Compliant

Regulation 9: Residents' rights

Staff members in this centre had completed training in a human rights based approach to care. The inspector spoke with four staff in detail on the day of inspection and found that staff members were committed to promoting and upholding residents' rights. Staff members described how they were satisfied that residents had increased choice and control in their everyday lives now that they had access to a day service team. Staff members showed the inspector the visual supports that are used with residents to offer choices and to explain the planned routine for the day.

One of the staff members told the inspector of how some of the restrictive practices in the centre had been reduced and how this was also upholding resident rights. The person in charge told the inspector that they were working with a member of the multidisciplinary team to implement rights restoration plans in respect of the remaining restrictive practices. However, due to the unsuitable layout of the property, there remained a number of restrictive practices which could not be reduced due to known risks. These restrictive practices impacted on residents' freedom as they could not freely access all parts of their home.

Judgment: Substantially 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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Michael's House Ballygall OSV-0005706

Inspection ID: MON-0048811

Date of inspection: 17/02/2026

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 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Service manager will continue to attend the centre and meet with the PIC regularly (Ongoing) Service manager will attend team meetings as required (Ongoing) Service improvement team will continue to meet monthly to ensure all agreed actions are completed. This will be reviewed as actions are completed (Ongoing) Defined and timebound actions are detailed on the service improvement plan to ensure that the service is safe and suitable to meet the residents' needs (Ongoing)</p>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>Flooring repair - completed Grouting - to be completed by the 27/03/2026 New mattress requested from the public health nurse – 31/05/2026 The PIC is liaising with the technical services team to arrange additional laundry facilities –30/04/2026</p>	
Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>There is ongoing engagement between the Director of CYP and SMH Director of Estates re proposed interim and long-term plans for the designated centre. Additional solutions</p>	

are being explored with all involved – Directors CYP and Estates, Ballygall PIC, Service Manager and MDT team. Once finalised a business case will be completed and escalated for funding within SMH and the HSE. – In the interim, following consultation with the PIC, Service Manager, MDT and Estates manager the following interim works have been agreed to help reduce some immediate risks

Immediate works

1. To reduce the number and frequency of Transitions install a set of pocket doors between SU bedroom and Sitting Room area (rooms FF_04 & FF_05 on floor plan)

The purpose of installing the pocket doors is to reduce the frequency of the service user having to egress onto the landing when transitioning from one of his rooms to the other. The impact of same will reduce potential for incidents to occur in the narrow landing area. The RP will measure the reduction in incidents that occur in this area as a result of the change.

2. Assist Staff Team with visual interactions when located in Breakaway Space FF_02, Replace current door with door that has enlarged viewing panel.

3. Reduce Staff interactions within Shower room, have new control valve control fitted outside of ensuite.

The ensuite referred to is FF06 on the floorplans. The purpose of proposed changes is to enable staff to remotely switch on and off the water supply, to reduce the requirement for staff to enter the resident's personal space to turn off the water supply. By locating the water valve external to the bathroom will reduce opportunities for incidents to occur. This will be monitored and reviewed.

4. Address visual impairment of SU when staff ascending stairs on landing by fitting convex mirror at top of landing.

To be completed by Date: End Q2 2026

Review to assess the impact Date: Start Q4 2026

Two high level proposals are being explored

Option 1: 78 meters squared extension
Option 2 : 56 meters squared extension

Pre Planning meeting will need to be held with DCC, The RP will seek a pre planning meeting with DCC as soon as possible. This will be completed by 30th of June 2026. The DOE has contacted DCC to request this.

SMH will need guidance from DCC regarding viability of planning application prior to instructing relevant professionals for design.

Full assessment by the relevant engineering disciplines Date: 31st December 2026

<p>A business plan will be produced simultaneously as the assessment by the engineer by 31st of December 2026.</p> <p>Proposed completion of works – 31st December 2027 subject to planning</p>	
<p>Regulation 9: Residents' rights</p>	<p>Substantially Compliant</p>
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <p>PIC is completing a review of local protocols for residents' restrictive practises with the support of psychology with the aim of having restrictive practices rights informed and minimal as possible - to be completed by 30/04/2026</p> <p>The PIC will continue to review all rights restrictions, document and report on them at team and management meetings and endeavour to reduce them to a minimum, documenting changes on the relevant Risk Assessment and Service Risk Register.</p> <p>Ongoing</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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/04/2026
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He, she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre	Substantially Compliant	Yellow	30/04/2026

	to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2026
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	19/03/2026
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	19/03/2026
Regulation 05(3)	The person in charge shall ensure that the	Not Compliant	Orange	31/12/2027

	designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	31/12/2027