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:	St Michael's House Ballygall
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Unannounced
Date of inspection:	07 October 2025
Centre ID:	OSV-0005706
Fieldwork ID:	MON-0045385

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

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 7 October 2025	09:20hrs to 17:30hrs	Jennifer Deasy	Lead
Tuesday 7 October 2025	09:20hrs to 17:30hrs	Sarah Barry	Support

What residents told us and what inspectors observed

This was an unannounced inspection to assess the safeguarding arrangements in the centre. The inspection was completed by two inspectors over the course of one day. Overall, this inspection found that there were serious risks to the safety of the residents and that the management systems had failed to ensure the safety and wellbeing of the residents living here.

The designated centre is registered to provide care and support to three young adults with intellectual disability and autism. The centre is designed to provide separate living spaces for each of the residents, with each resident having their own living room, bedroom and bathroom. The centre also provides a communal kitchen, sitting room and a garden with playground facilities. It is located close to Dublin City Centre near many public amenities.

The centre is provided with two buses to enable residents to access the community and their preferred activities. Inspectors saw, on arrival, that one of the buses was damaged. The person in charge told inspectors that the bus was not in use and was waiting on repairs. Inspectors were told that this was having an impact on the capacity of staff to facilitate residents to engage in activities.

The person in charge had recently commenced in their role and spoke to inspectors regarding the residents' needs and the service needs. The person in charge had identified that there were deficits in many areas of service provision and described measures they had taken, since commencing in their role, to address these risks. This will be discussed further in the capacity and capability section of the report.

Inspectors were told that one resident was at day service; however, the remaining two residents did not have access to day service and were supported from home. The inspectors were told that day services had been recently identified for both residents although there was no official date for when they would be able to start there. On reviewing daily activity records for both of these residents, it was seen that they had very limited opportunities to engage in personally meaningful activities, in particular outside of the designated centre. Staff members spoken with told inspectors of their concerns regarding the lack of stimulating activities for residents.

Inspectors did not directly engage with most of the residents due to known risks. Inspectors were told that some residents could become anxious around unfamiliar people and that this could result in adverse incidents. One resident was being supported with their personal care needs when inspectors arrived. They later went for a drive on the bus and then went back to their living space. Inspectors did not meet this resident.

Inspectors were told that it was difficult to engage with this resident safely, and to adequately supervise them to ensure their safety, due to the layout of their living

space. Inspectors saw, and were told, of two serious adverse incidents which had occurred for this resident due to the inadequate design of their living space.

As a result of this, an urgent action was issued to the provider on the day of inspection and the provider was required to submit a risk assessment and risk control measures within a short time-frame, to the Chief Inspector as part of their response. The provider submitted a comprehensive response which provided an assurance that measures had been put manage the risk more effectively. This will be discussed further in the next two sections of the report.

Another resident was supported from home for much of the morning. They were observed being supported with their breakfast and playing with sensory activity items. Inspectors also saw this resident using the garden facilities during the morning. Inspectors observed the resident engage in a behaviour which may have compromised their dignity. Inspectors were told that this was a typical behaviour for the resident. Inspectors also saw this resident engaged in incidents of self-injurious behaviours. Staff members spoken with expressed concern about how the design of the centre was contributing to incidents of self-injurious behaviour for the resident.

Inspectors met the third resident when they returned to the centre from day service. They came in to the communal living room and greeted inspectors. They appeared relaxed and comfortable in their home. Staff members told inspectors that they felt the service was meeting the needs of this resident; however, they expressed concerns regarding the arrangements to support the other two residents to have a good quality of life and to receive care in a safe and consistent manner.

Inspectors completed a walk around of the centre with the person in charge. Each resident's living compartment was reviewed while the resident was out of the service, so as not to cause undue distress to the residents or to pose a risk to inspectors or staff members.

The communal kitchen and living room were seen to be well-maintained and were warm and comfortable. However, inspectors were told that, while the kitchen was well-maintained, it was not designed in a manner which supported residents to engage in activities of daily living in this space. The kitchen was cramped and posed some risks; for example, the person in charge had identified that an induction hob was required to mitigate risks.

Inspectors spoke to three staff, including the person in charge, in detail over the course of the day. A consistent concern raised by staff was that they felt that the centre was not designed in a manner suitable to meet the needs of all three of the residents. The design of the centre posed risks in respect of its layout as staff members could not safely retreat when residents were anxious or engaged in heightened behaviour. One resident was seen by inspectors to become distressed by the presence of unfamiliar people in the communal sitting room and engaged in self-injurious behaviours. For this reason, inspectors based themselves from one of the other resident’s living rooms in order to review documentation and so as not to cause distress to the resident.

Inspectors saw that there was upkeep required to residents' living spaces. Some of the residents presented with behaviours which had resulted in damage to the centre's furniture and fittings including skirting boards, couches and floor coverings. Other furniture, such as desks, had become damaged over time and needed upkeep or replacement. Some residents' behaviours also impacted on the infection prevention and control (IPC) arrangements for the centre. Inspectors saw that the walls of a living room and bathroom were stained and dirty. These issues are discussed further in the quality and safety section of the report.

Overall, the inspection found that there was a very high level of non-compliance with the Regulations. The provider had failed to adequately monitor the quality and safety of care and there were a number of risks to the safety of residents.

In response to the high levels of non-compliance found on the 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 describe, in more detail, the governance and management arrangements of the centre and how these impacted on the quality and safety of care.

Capacity and capability

This section of the report describes the oversight arrangements of the centre and how effective they were in ensuring that residents were in receipt of good quality care. This inspection found that there were significant deficits in the provider's oversight of the centre and that this had resulted in adverse incidents for residents, and had a negative impact on their human rights and on their quality of life.

The provider had implemented management systems in the centre; however, these were ineffective in monitoring the standard of care for residents and in driving service improvements. The management systems had failed to ensure that staff members were adequately supervised or were in receipt of suitable training. There was an absence of consistent protocols to guide staff in providing suitable care to residents in line with their assessed needs and risks posed by these.

The provider's audits had failed to identify serious risks and there was an absence of risk assessments to control for these. Additionally, there was a failure of the provider to implement a strategic plan to ensure that residents were in receipt of person-centred and safe services. Inspectors found that the impact of this was that residents were living in an unsafe environment and were not being supported to achieve a good quality of life.

The residential centre was not being governed in a manner which ensured that it was being operated in line with statutory requirements. Inspectors were told by staff members that there were long-standing issues with the oversight arrangements of

the centre. Inspectors saw that the provider's information governance arrangements to gain information on the compliance of the service with the legislation and regulations were also ineffective. The provider's six monthly unannounced visit and annual review did not comprehensively identify risks to the quality and safety of care or implement action plans to address these risks. Action plans which were devised were not progressed.

A new person in charge had been appointed to the centre in recent weeks, and inspectors found that they had identified many of the service deficits and were endeavouring to implement systems to address these. For example, they had introduced a restrictive practices register, were commencing staff supervisions and had made arrangements to ensure continuity of care for residents in regards to the staffing arrangements. However, while the local management arrangements had been improved, inspectors found that the provider's oversight arrangements required enhancement to ensure that areas of non-compliance with the Regulations which were outside of the remit of the person in charge were accurately and consistently identified and responded to.

Staff members spoken with demonstrated a commitment to supporting residents to achieve a good quality of life; however, they expressed concern regarding the lack of oversight by the provider over the preceding months and the lack of consistent guidance on how to best meet residents' needs. While staff members had access to a training and development programme, inspectors were told by staff that it had been their responsibility to monitor their training needs. The result of this was that there was a high level of non-compliance with mandatory and refresher training and it could not be established that all staff members had the necessary skills to provide care and support to the residents.

Regulation 15: Staffing

The inspectors found that the centre had sufficient staff in place to meet the needs of the residents. The staff team in the centre was led by the person in charge and consisted of a staff nurse, social care workers and direct support workers. There were four to five staff on duty during the day and two waking staff at night.

The person in charge maintained a planned and actual roster in the centre. One inspector reviewed the rosters for the month of September and August and found that were was a reliance on relief and agency staff to cover all shifts in the centre. However, it was a core group of relief staff who were made up of staff who had previously worked with the residents and centre dedicated relief staff. There was also a small amount of agency staff usage in the centre.

Prior to the inspection, there had been staff shortages in the centre. Three new staff had recently joined the staff team and two staff had been redeployed from other centres operated by the provider. On the day of the inspection, there were two WTE

deficit in the staff team. There was plans in place to address this with more staff coming on board later this month.

The inspectors reviewed the staff files of five staff members working in the centre. Files reviewed met the requirements of Schedule 2 of the regulations. The inspectors reviewed the records in relation to vetting by An Garda Síochána for all staff working in the centre and found all staff had up to date records on file.

Judgment: Compliant

Regulation 16: Training and staff development

There were deficits identified in respect of the support and supervision of staff members, and with compliance with mandatory and refresher training. On the morning of the inspection, the inspectors requested up-to-date training records to include all staff working in the centre. Near the end of the inspection, inspectors were provided with a training audit which did not demonstrate the dates staff had completed training and did not include all staff working in the designated centre. Therefore, it was unclear if gaps identified in training were where staff required refresher training or had not completed the initial training. Deficits with training compliance meant that the provider could not be assured that all staff members had the training required to provide suitable care and support to the residents.

It was unclear if four staff had completed safeguarding of vulnerable adults training. Eight staff required either refresher or initial training in positive behaviour support. There were also gaps in training in relation to Feeding, Eating, Drinking and Swallowing (FEDS), Emergency First Aid, First Safety and Hand Hygiene. The person in charge had begun the process of creating a comprehensive training record for the centre but this was not in place at the time of the inspection.

Since taking up the role, the person in charge had completed supervision meetings with five staff members. There was a schedule in place to complete a first supervision meeting with the remaining permanent staff members this month. A review of the supervision records for three staff members demonstrated the topics discussed included supporting the residents, working as part of a team, new guidelines and leadership/learning. A review of these supervision records demonstrated how unsupported some staff felt prior to the new person in change taking up the role. They demonstrated that staff felt unsupported in their communication with residents and how to best support them with needs.

Prior to the new person in charge taking up their role, it was unclear how frequently staff were receiving supervision. For example, during the last provider audit in the centre, the staff supervision records could not be found. A review of documents in the centre showed prior to the new person in charge commencing in the centre, staff felt unsupported when serious incidents occurred in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and oversight arrangements in this centre had failed to ensure that the service provided was safe, appropriate to residents' needs and was consistently and effectively monitored. The provider's management systems had not ensured sufficient oversight of the quality and safety of care. Inspectors found numerous risks which had presented in the centre for a considerable length of time that had not been adequately identified, assessed and controlled for by the management team at local and provider level. For instance, risks pertaining to the ingestion of inedible items by residents, injury as a result of self-injurious behaviours, a lack of staff supervision and an absence of comprehensive care plans to guide staff had not been identified and responded to appropriately.

This inspection found that the local management arrangements and the provider level oversight arrangements had been ineffective in identifying and addressing risks to the quality and safety of care to residents. There was a high level of non-compliance identified on this inspection with evidence of negative impact on residents' rights, safety and wellbeing. These deficits had not been identified by the provider and there was no strategic plan in place to enhance the quality of the service.

Improvements were required in the oversight arrangements and prescribed audits of care to accurately reflect the issues in the centre. The provider's most recent six monthly audit, which took place in June 2025, had gaps as a number of documents could not be found in the centre on the date of the audit. These included the previous six monthly audit, incident reports, staff supervision records, unit fire risk assessment and "All About Me" documents for each resident. The audit identified 27 actions with no completion date listed. The person in charge confirmed that they had completed five of these actions since taking up their role and the rest remained outstanding. The audit had not identified the maintenance issues in the centre aside from the repainting requirements.

The most recent annual review for the centre took place in March 2025. Three actions were identified in this audit. All actions remained incomplete and no completion date was prescribed in the review. The person in charge had escalated one of the outstanding actions as a red risk in the centre. This risk related to the lack of a day service for two of the residents and the impact on their quality of life.

An infection prevention control audit had taken place in the centre in October 2024. This had identified deficits in respect of the fixtures and fittings in the centre, such as the material on the stairs needing replacement and a new couch being required for one resident. Both of these actions remained outstanding on the day of the inspection and posed a risk to one resident due to an assessed need and known behaviour.

Inspectors spoke with two staff members in detail on the day of inspection. Staff members communicated to inspectors that the oversight arrangements for the centre were ineffective. They reported that there was a a failure of the provider to properly induct new staff and that staff members did not have access to residents' care plans and risk assessments. The result of this was a lack of consistency in the provision of care between staff members. One staff member described how they had devised a written protocol in order to guide agency and relief staff in understanding a resident's routine as there was an absence of a formal protocol to guide new staff. Staff members spoken with identified that the service was not meeting the residents' needs and posed risks to their wellbeing. Staff members told inspectors that they felt unsupported when they had escalated issues and risks to the provider in the past.

Judgment: Not compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents. Overall, inspectors found that there were numerous deficits in respect of the quality and safety of care.

Of particular concern to the inspectors was that it was not demonstrated that the designated centre was designed or laid out in a manner suitable to meet the needs of the residents. There had been a number of adverse incidents involving residents as a result of the staff team's inability to adequately supervise residents. These incidents also occurred due to a lack of comprehensive care plans and risk assessments in respect of residents' needs. For example, one resident presented with a risk regarding consumption of inedible items; however there was no risk assessment implemented in respect of this need.

The layout of the centre had also resulted in a number of injuries to the staff team. Staff members reported that areas of the centre were difficult to quickly step away from should residents engage in behaviours of concern. This risk was compounded by the poor oversight arrangements of the centre and the inconsistent staffing over the past 12 months, as communicated to inspectors by the staff team on the day of inspection.

Adverse incidents involving residents were not effectively reported or reviewed and there was a failure to implement leanings from adverse events to prevent future similar occurrences. There was an absence of protocols or risk assessments to guide staff in managing risks which were posed by the assessed needs of some of the residents.

Safeguarding incidents were also not reported in line with statutory requirements. Inspectors found that improvements were required to the oversight of safeguarding risks in the centre, including those posed by residents' behaviours which could impact on their own dignity or the wellbeing of others.

There were a high number of restrictive practices in place in the centre. These were inconsistently recorded, monitored and reported to the Chief Inspector as required by the Regulations. Since commencing in their post, the person in charge had implemented a new restrictive practices recording log and had sought advice from the provider's multidisciplinary team and rights review committee regarding these practices.

Residents' individual assessments and care plans had not been reviewed in a timely manner and were not informed by relevant multidisciplinary professionals. Some residents' assessments were in the incorrect format and were inconsistently completed, with sections being left blank or questions unanswered. It was not demonstrated that residents' needs had been comprehensively assessed and that there were clear procedures and care plans for staff to follow in respect of each assessed need. The person in charge had also identified this as a service deficit and had made several referrals to the provider's multidisciplinary team for reviews and updating of these plans.

The premises of the centre required upkeep and maintenance. Residents' personal living spaces appeared to be furnished and decorated in line with their needs and preferences; however, there was damage to items of furniture, bathroom fixings and floor coverings.

Staff members expressed concern regarding the lack of meaningful and engaging activities for residents. Two residents did not have access to a day service at the time of inspection and, due to one of the centre's buses being damaged, there were restrictions on the availability of community activities for residents. In reviewing daily notes and in speaking with staff, inspectors saw that residents had very few opportunities to make meaningful connections with members of the community or other peers.

Regulation 10: Communication

Residents in this centre presented with communication support needs. The inspectors reviewed the file of one of the residents with communication needs. It was seen that their communication support plan was out of date and there was an absence of an assessment by an appropriate multidisciplinary professional to inform this plan.

Staff members spoken with told inspectors that they had difficulties communicating with residents and that this resulted in adverse incidents. Inspectors saw, in reviewing supervision records, that staff discussed how it was difficult to communicate effectively with residents to identify the cause of their distress and the

difficulties that this resulted in. Some residents were reported to use Lamh (a manual sign system) or visual supports to assist them with communication; however, it was not demonstrated that staff members had received training in these communication systems.

The person in charge, since commencing in their role, had identified this as an area for improvement and had made referrals to the provider's multidisciplinary team for communication assessments. It was not established on the day of inspection that these referrals had been accepted.

Judgment: Not compliant

Regulation 17: Premises

The premises of the centre required upkeep in several areas. The person in charge communicated to inspectors that they had identified this and had escalated it to the provider's maintenance team. There were a suitable number of bathrooms and each resident had their own bedroom and living room. A communal kitchen was well-maintained and was used to prepare meals for residents.

Inspectors found that the centre was not designed or laid out to meet the residents' needs; however, this has been actioned under Regulation 5: Individual Assessment and Personal Plan.

The following areas of the premises of the designated centre required upkeep:

- a skirting board was missing in one section of a resident's living room
- a desk in resident's living room was damaged and could not be effectively cleaned
- there was minor maintenance needed to a downstairs bathroom due to a chipped countertop and associated infection prevention and control (IPC) risks
- a desk was damaged in a downstairs resident's bedroom
- external blinds/shutters needed to be added to a downstairs bedroom window
- in the upstairs living room inspectors saw that a couch was very worn
- paint was chipped away on upstairs skirting board
- the walls in an upstairs sitting room and bathroom were seen to be dirty
- the sink cabinet in an upstairs bathroom was very damaged
- the banisters were very worn and the paint had peeled away
- the stair covering very damaged and had been removed/peeled away in places meaning it could not be cleaned and posed a risk of trips or falls

In one of the resident’s bedroom, there was a large box mounted with a perspex cover mounted on the wall, the purpose of which was to contain a TV. This box was empty on the day of the inspection and the inspector was advised that it had never

held a TV as the resident did not want a TV in their room. No review had taken place of whether this should be removed. The bedroom needed repainting throughout, as did the entire compartment.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A serious risk was identified on the day of inspection relating to the management of the risk of a resident ingesting inedible items (Pica). Inspectors saw, and were told, that a resident had bitten into a toxic item in January 2025. The resident was unsupervised at the time and was found with three of these items in their hands and evidence of a toxic substance on their lips and hands. There was an absence of comprehensive risk assessments or control measures to prevent a reoccurrence of a similar incident, and inspectors saw that a second, similar incident where the resident had bitten into an inedible, and potentially toxic, item occurred in May 2025. The provider had also failed to complete a critical incident review to identify any lessons learned and to prevent future risks.

An urgent action was issued verbally on the day of inspection regarding this risk and in writing the day after the inspection. The provider was given a short time-frame to submit a comprehensive risk assessment with associated control measures to the Chief Inspector. The provider's urgent compliance plan response provided assurances that the urgent risk had been mitigated.

Staff members communicated to the inspectors that they had endeavoured to raise concerns regarding risk management to the provider; however, their concerns were not adequately responded to. On both incidents, where a resident had potentially ingested toxic items, the staff team contacted the nurse manager on call for guidance. The inspectors saw that there was a risk assessment for battery/chemical storage; however, this provided general control measures which were not specific to the risk identified. Staff members spoken with stated they were not aware of any risk assessments for this particular risk and that there was an absence of protocols to guide them in managing the risk. The provider's audits, as detailed under Regulation 23, had also failed to identify gaps in compliance and to implement action plans to address the risks to residents' safety.

Inspectors saw, on a review of residents' behaviour support plans, that some behaviours posed infection prevention and control (IPC) risks. There was an absence of a specific risk assessment in this area to guide staff in managing the risks posed by these behaviours. Inspectors saw that one living room and bathroom required enhanced cleaning.

Inspectors were told, and saw through reviewing adverse incident report forms, that there was a risk of physical assault to staff due to the inappropriate layout of the centre. The inspectors saw that there were incidents where staff members had been

assaulted as they could not safely and quickly step away from residents when they engaged in behaviours that challenge. These incidents took place both upstairs and downstairs.

Inspectors saw on incident report forms, and were told, that downstairs a keypad prevented staff from quickly exiting a resident's living space. In one incident in 2025, a staff member was assaulted as they could not exit quickly enough due to the delay it took to access the keypad.

In the upstairs space, the narrow landing posed a risk to staff as staff had insufficient space to safely retreat during incidents of concern. The inspectors saw that a staff member had been injured in November 2024 on the upstairs landing. Staff members spoken with expressed concern over the difficulties that the upstairs of the centre posed in ensuring they could safely supervise and support the resident who lived there.

There was also a risk of injury to a resident from a glass panel in their sitting room door. Inspectors were told that this resident had broken a glass panel earlier in the year as a result of self-injurious behaviour. Inspectors were told that the resident had not been injured; however, staff described receiving a lack of support from the provider in responding appropriately to the incident and ensuring the resident's safety, as they continued to attempt to access the panel which contained broken glass. Staff members expressed that the on-call management systems had been ineffective in providing them with adequate guidance and support.

The panel was replaced by a Perspex panel; however inspectors were told that this was due to be changed back to a glass panel. Staff members expressed concern regarding the potential for a similar incident to reoccur and also for the ongoing potential for further injury to the resident, who regularly engaged in self-injurious behaviours on the window.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Inspectors were told by staff members that the designated centre was not designed or laid out in a manner suitable to meet the needs of the residents. In particular, concerns were raised about two of the residents' living spaces and the risks that these posed including the risk of injury to residents as a result of self-injurious behaviour, and of injury to staff due to behaviours of concern.

Inspectors were told that one resident's living space caused distress to them as their routine was interrupted by being able to see people coming and going from communal areas. Inspectors saw that there was an increase in self-injurious behaviours displayed by this resident when the inspectors were in the communal

room. When inspectors moved to another area of the house the behaviours decreased in frequency and intensity.

Overall staff members communicated to the inspectors that the environment was not conducive to supporting residents in the best way in line with their needs and preferences.

Inspectors reviewed one resident's individual assessment in detail. A printed version of this was out of date, having been last updated in 2023. The inspectors were provided with an online version which had been last reviewed in November 2024. This version was seen to be the "child" version of an individual assessment and had not been updated onto an adult format in line with the resident's age and needs.

The assessment did not detail any information on the resident or the family's views of their health and social care needs and was not linked to any goals. The assessment provided a space for the provider to detail if an action plan was required in respect of an assessed need. Most of these areas were seen to be blank. For example, the safety section of the report did not provide any information on the procedure required to ensure the resident's safety in the event of fire or emergency and did not direct the staff team to any associated care plans.

There was an absence of comprehensive care plans for assessed needs. Care plans which were in place were out of date; for example, a family contact care plan was last updated in 2021. Staff members were not familiar with residents' care plans or individual assessments and some staff were unsure of how to locate these plans.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Inspectors saw that there were a high number of restrictive practices implemented in the centre due to the risks posed by residents' assessed needs and behaviours.

Restrictive practices had been inconsistently recorded in the centre and inconsistently reported to the Chief Inspector over the past 12 months; for example, inspectors saw restrictions which had not been notified to the Chief Inspector, such as restrictions on residents accessing water in the bathrooms.

However, the new person in charge had identified this as an area for improvement and told inspectors that they had introduced a restrictive practices recording log and were in the process of introducing rights restorations plans for each resident. The person in charge had also worked with the multidisciplinary team to reduce or eliminate some of the restrictive practices in recent weeks. The inspectors reviewed

the new restrictive practices log and saw that it was comprehensive and assisted the management of the centre in having oversight of restrictive practices.

Inspectors saw that one resident had a positive behaviour support plan which was in draft form since April 2025. Inspectors were told that this had not been completed due to changes in the management of the centre and to the provider's multidisciplinary team members. Inspectors saw, and were told, that the person in charge had recently met with the provider's multidisciplinary team in order to update the behaviour support plans.

Judgment: Substantially compliant

Regulation 8: Protection

The inspectors reviewed the intimate care plans on file for one resident and saw that they were out of date. They were not specific or detailed and did not guide staff in comprehensively meeting the resident's intimate care needs.

The inspectors saw one resident engage in a behaviour in the garden which posed a risk to their dignity. Inspectors were told by staff that this behaviour occurred at least a few times per week. Inspectors saw that there was one incident logged where the resident's dignity had potentially been impacted by a similar behaviour in August 2025. There was a lack of a safeguarding plan or risk assessment to ensure the resident's dignity was upheld.

There was one recorded incident of a negative peer to peer interaction in September 2025. Inspectors were told by staff members that one resident had entered another resident's living space, had attempted to destroy their property and had attempted to physically assault the other resident. The impacted resident was protected by staff members and, inspectors were told, was removed from their living space until the other resident could be encouraged to return to their own space.

Inspectors were told that the incident had been reported to the designated officer but it was not reported to the Safeguarding and Protection Team or the Chief Inspector. It was unclear why the safeguarding policies and procedures had not been followed in respect of this incident and there was a lack of a safeguarding plan to prevent future similar events.

As detailed under Regulation 16, it was also not established that all staff had received training in safeguarding vulnerable adults.

Judgment: Not compliant

Regulation 9: Residents' rights

Staff members expressed concern regarding the lack of meaningful activities available on a daily basis, in particular for two of the residents who did not have access to day services at the time of the inspection.

Inspectors were told that one resident engaged in very few meaningful activities on a daily basis. They went for drives but did not go for walks in the community. They showered twice a day as they enjoyed water play but generally spent a lot of time alone and staff communicated that the resident was very isolated

Some residents had previously engaged in more meaningful activities, such as swimming, however they were no longer availing of these. Inspectors were told that swimming had ceased for one resident due to behaviours that posed an infection prevention and control risk; however, there was an absence of planned alternative activities for the resident to engage in.

A review of the daily notes for two residents from 01 October to 06 October 2025 showed that they engaged in very few meaningful activities. The only activity listed for one of these residents across that period was going for a drive on the centre's bus. The other resident was noted to have gone for a drive on two occasions and on other days spent their time listening to music, going into the garden or playing with toys.

Inspectors were told that the centre's bus had been damaged and was out of use for approximately two months prior to the inspection. The impact of this was that it was difficult to complete community activities with the residents as the bus was required by other residents at specific times in line with their routines and assessed needs.

Residents and their representatives were not consulted with regarding their individual assessments and care needs. It was not demonstrated that residents were supported to have freedom and control in their daily life to their fullest extent.

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

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

Inspection ID: MON-0045385

Date of inspection: 07/10/2025

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has ensured that all online training has been completed by staff. The PIC has ensured that all outstanding In Person training has been scheduled. The PIC has ensured that TIPs training will be completed by the end of January 2026 All PBS training will be completed by 25/02/2026 (refresher and new staff) PIC has updated the training matrix to reflect this and this is available for review.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A Service Improvement team chaired by the Director of Service, and informed by a Terms of Reference will have its first meeting by the 1/12/2025 The provider shall ensure that the required governance and management structures and systems are in place in the centre. All actions from the Reg 23 audit by the Service manager six monthly audit have been reviewed and in progress for completion A further 6 monthly audit will take place before Dec 31st 2025 The PIC has established a new Supervision meeting schedule to ensure that all staff receive appropriate individual support. All staff members will have received a supervision meeting in Q3 and have a further meeting scheduled for Q4.	

The Service Manager will attend monthly team meetings as required to support the PIC and staff team

Regulation 10: Communication	Not Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: An SLT will complete communication support plans for all residents to support staff to comprehensively engage with all residents to ensure they are able to clearly communicate their needs, rights and choices.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Registered Provider will ensure that a comprehensive review of the suitability of premises is completed with the support of the technical services department, a suitably qualified architect, the management of the designated centre and members of the MDT. Once this is complete plans can be drawn up to allow the Director of CYP & SMH Director of Estates to discuss costings and logistical planning. Once this is complete a business case will be completed and escalated for funding within SMH and the HSE The PIC will ensure that all required remedial works are escalated to the technical services department for completion by end of Q1 2026	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: All Risk Assessments and risk register are being reviewed and updated by PIC and will be completed by 30th November 2025. All incidents will be reviewed by the PIC and MDT monthly, discussed and reviewed at monthly team meetings and at the Service Manager and PIC monthly meetings to ensure all follow up actions are completed and any learnings used to reduce and eliminate	

reoccurrence
All incident forms are sent to the MDT (psychology) weekly
Incidents will be reviewed and where appropriate escalated to the Registered Provider with After Action Reviews completed for all category 2 and 3 incidents as per policy and ICMs convened where necessary.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC will ensure that all personal & support plans are being reviewed and updated to ensure that each resident has a comprehensive assessment of their needs in place and relevant care and support plans developed to enable the resident to live their best life. The Person Centred Planning (PCP) Coordinator has carried out a PCP audit on the 14th of November 2025 and will provide any additional guidance and/or training to staff if required regarding Assessments of Need.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC and Psychologist have completed the final review and update of the PBS plans for all residents and they are no longer in draft format. The PIC will ensure that these are kept under review at all times for the residents to accurately reflect their needs and supports and updated as required at a minimum yearly. The psychologist attends all staff meetings in the centre.

PBS in person training has been scheduled for all outstanding staff. This will be complete by 25/02/2026.

The PIC will ensure that all restrictive practices will be reviewed and submitted to the Organisational Positive Approaches Monitoring Group for approval and has compiled a comprehensive log to record and track all restrictive practices.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Safeguarding training for all staff is complete.
Safeguarding Audit completed by Designated Officer on 11/11/2025.
Any outstanding Safeguarding Notifications have been submitted as per policy
Team based training for staff will be provided by the by the Safeguarding Team by end of Q1 2026
Additional leadership support provided to facilitate the assessment and updating of Intimate Care plans

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
An SLT will complete communication support plans for all residents to ensure their rights and choices are effectively communicated and supported.

The Person Centred Planning (PCP) Coordinator completed a PCP audit on the 14th of November 2025 and is scheduled to attend a team meeting in January 2026 and will provide additional guidance and support to staff.
Day service to commence for one resident by 30/11/2025 and a transitional plan has commenced.
The day service for the second resident to commence by Feb 28th, 2026
The PIC shall ensure that comprehensive assessments of needs and support plans for all residents are completed and reviewed by the 30th November 2025 and updated as required at a minimum annually
The PIC has reviewed the residents daily activity schedule and new meaningful activities will take place for the residents and will be recorded in their daily reports.
The PIC with support from the MDT (OT, Psychology and frontline team) is actively reviewing residents activity schedules to support a more meaningful day and this will be enhanced when they start their day service.

Review of suitability of premises with technical services, Architect, MDT.
Submission of outline plans by Architect
ICM held on the 13th of November for one resident to ensure staff safety while supporting resident upstairs and to review supports in place to ensure the personal space for residents is maintained.
The PIC will ensure ongoing review of ICM recommendations and completion of all identified actions.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	30/11/2025
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	25/02/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	17/11/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/03/2026

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	17/11/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	17/11/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	17/11/2025
Regulation 23(2)(a)	The registered provider, or a	Not Compliant	Orange	17/11/2025

	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.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	17/11/2025
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to	Not Compliant	Orange	17/11/2025

	raise concerns about the quality and safety of the care and support provided to residents.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	17/11/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/11/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently	Not Compliant	Orange	30/11/2025

	as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/03/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/03/2026
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/11/2025
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the	Not Compliant	Orange	30/11/2025

	designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	30/11/2025
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	30/01/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive	Substantially Compliant	Yellow	30/11/2025

	procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	25/02/2026
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	30/11/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the	Substantially Compliant	Yellow	30/11/2025

	shortest duration necessary, is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	17/11/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	17/11/2025
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Not Compliant	Orange	30/11/2025
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	17/11/2025

Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	30/11/2025
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.	Not Compliant	Orange	30/11/2025
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	31/03/2026