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:	Avalon House
Name of provider:	Health Service Executive
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	02 April 2025
Centre ID:	OSV-0003694
Fieldwork ID:	MON-0038001

About the designated centre

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

This designated centre provides full-time residential care for seven adults with an intellectual disability, both male and female and over the age of eighteen. The centre is a large detached bungalow a few kilometres outside the nearest town. The centre comprises fourteen rooms including two small storage rooms and a lobby area, and a self contained apartment with access to the main house. There is a kitchen, dining room, sitting room, utility room and six bedrooms, all with en-suite facilities. There is one separate bathroom and one wheelchair accessible toilet. The centre has a large garden and patio area at the back of the house, with a garden cabin for the use of residents for activities or pastimes. It has its own transport; a wheelchair accessible vehicle and a people carrier. The person in charge works full-time in this centre and the staff team includes both nurses and health care assistants. Staff provide support to residents during the day and at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Wednesday 2 April 2025	10:15hrs to 17:30hrs	Julie Pryce	Lead
Friday 4 April 2025	10:45hrs to 17:30hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This inspection was an announced inspection conducted in order to monitor on-going compliance with regulations and standards and to help inform the registration renewal decision.

There were seven residents living in the centre, although only six of them were present during the inspection. The inspector met and spent some time with all six residents, and had a chat with those who communicated verbally.

One of the residents had their own self-contained apartment adjoining the main house so that they could spend time in the communal areas or in their own apartment as they chose, or as their needs indicated. This apartment had been added to the premises since the previous inspection in response to the needs of the resident. As a result of this change there had been a significant reduction in incidents which impacted others, and in the number of complaints made by other residents. There had also been a significant improvement in the incidents of behaviours of concern which the person in charge and staff members described as being partly due to the resident having more control over their daily choices.

The resident invited the inspector to visit their apartment, and it was evident that they were very proud of their own living space. They pointed out various items in the apartment which was nicely furnished and full of their own personal items. They spoke about enjoying gardening, and the apartment opened up directly onto the garden that they enjoyed, with views from the windows onto the gardens.

There was a cabin-like structure in the garden which had been constructed to provide an additional recreational area for all residents, but which was mostly enjoyed by the resident of the apartment. The resident spoke about using this area, and also told the inspector about their recent holiday, and particular experiences that they had enjoyed.

Other residents were observed to be comfortable in their home, and to be offered support from staff in a caring and knowledgeable manner. As residents were going about their morning routine, some in a very leisurely manner, staff were observed to be familiar with their preferences, for example offering their favourite drinks and snacks. One resident had a chat with staff and the inspector about the day ahead and all their plans. They had a mobility aid which they had given a nickname, and it was clear that they found it a support.

In another area of the house a resident could be heard chatting and laughing with staff, and later the inspector heard them singing along together. Later in the afternoon a musician attended the centre to provide music therapy, which was a weekly event for residents. The inspector observed residents to be joining in with enthusiasm, and saw that the therapist knew them all and was including them by

name.

The inspector spoke to three staff members and the person in charge during the course of the inspection, and found that they were all knowledgeable about the care and support needs of residents. They spoke about supporting the rights of residents to make choices and decisions, and were familiar with the ways in which the behaviours of residents might affect their daily lives. For example they spoke about the best way to manage a resident who might refuse their meal. They were aware that to try and persuade the resident might have a negative impact on them, so the staff would wait for a while before offering the meal, or an alternative, for a second or third time.

Staff spoke about the importance of offering regular activities to residents in accordance with their needs and preferences. They spoke about the preference of some residents for outings and walks, and for sensory or home-based activities for others.

The inspector met family members of two residents during the course of the inspection. Family members said that they knew who to approach if they had any concerns, and described the contacts that they had made with concerns. They had received a response to any contact they had made, however, they were not always satisfied with the follow up. For example, one family member remained dissatisfied with the follow up in terms of their relative's requirement for regular chiropody, which was consistent with the findings of this inspection, and will be discussed further under Regulation 6: Healthcare of this report.

Family members also expressed the opinion that they would like a more structured form of contact and information from the centre. This was discussed with the person in charge and assistant director of nursing at the close of the inspection, and assurances were given that this matter would receive their attention. The inspector found that other issues raised by family members were under constant review by the person in charge and staff team, and were being monitored appropriately.

Other comments made by family members included that they felt that their relative was very happy, that they called the designated centre home, and that the staff deliver genuine care, and they know their 'relative's ways'.

The centre had a system of recording both complaints and compliments, and recent compliments included two comments from allied health professionals in relation to the high standard of care offered to residents, and another from the family of a newly admitted resident, who said that their family member already referred to 'going home' when returning to the centre.

Overall residents were supported to have a comfortable and meaningful life, and had various activities in accordance with their needs and preferences. There was a good standard of care and support in this designated centre, although improvements were required in the support offered to residents in managing their personal finances, in maintaining consistent staffing levels, in the management of documentation and in some of the monitoring processes to ensure effective

oversight of these issues.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies in place, although improvements were required to ensure that the system of auditing was effective.

Improvements were also required to ensure that all documentation relating to the care and support of residents was clearly stored and readily available to staff.

There was a competent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents, although improvements were required in maintaining consistent staffing numbers.

Daily supervision was appropriate, however, the required formal supervision conversations were not all up-to-date.

There was a clear and transparent complaints procedure available to residents, and both complaints and compliments were recorded and monitored.

Regulation 15: Staffing

There was a consistent staff team who were known to the residents, including any relief staff. A planned and actual staffing roster was maintained as required by the regulations. However, the inspector was not assured that there were always sufficient numbers of staff to meet the needs of residents both day and night.

On both days of this inspection a staff member called in sick and could not be replaced. A review of the roster for the three weeks prior to the inspection indicated that there were seven occasions where there was a shortfall of one on the usual staffing numbers. In addition, an additional staff shift had been introduced in the evenings in response to a previous inspection. When resident numbers had reduced in 2024 this shift had been discontinued, however, the complement of residents had been back up to the full seven since January 2025, and this shift had not been re-introduced.

However, there was a consistent staff team who were known to residents and who were familiar with their support needs. Where agency staff were required they were

always known to residents. In addition, there was always a staff nurse on duty, in accordance with the assessed needs of residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

All mandatory staff training was up-to-date, and staff had also received training in dementia in intellectual disability, wound management and tissue viability and the management of percutaneous endoscopic gastrostomy (PEG) in accordance with the assessed needs of residents.

There was a schedule of supervision conversations in place with two such conversations scheduled for each staff member. The inspector reviewed the records of these conversations for three staff members, and found that two of the staff had had the required two conversations in the previous year, but that one of them had only one recorded supervision conversation every two years since June 2021.

Staff told the inspector that they found their supervision conversations useful, that they were supported to raise issues, and that they received useful feedback including areas for improvement. However the inspector was concerned that this form of supervision was not consistently facilitated.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this structure and their reporting relationships.

Various monitoring and oversight systems were in place. An annual review of the care and support of residents had been prepared in accordance with the regulations and six monthly unannounced visits on behalf of the provider had taken place. The annual review was a detailed report of the care and support offered to residents. Required actions were identified in this annual review, and in the reports of the six-monthly unannounced visits, and a sample reviewed by the inspector had been completed within the required timeframe.

A range of audits had taken place including audits of medication management, of residents' finances and of residents care plans. However, the audits of finances had not identified the arrears in the payment of bills for residents as outlined under Regulation 12: Personal possessions in this report. In addition the audit of care plans did not identify the issues relating to the duplications and retrieving of documentation outlined under Regulation 5: Individualised assessment and personal

plan of this report.

Staff team meetings were held approximately every two months, and records of the discussions at these meetings were maintained. However there was no system of monitoring to ensure that staff who were not present at the meetings had read the minutes and were aware of the issues discussed.

Otherwise communication with the staff team was well managed via a handover at the change of shift and a communications book.

Staff were appropriately supervised on a daily basis, with leadership from the person in charge and also from the registered nurses on duty each day.

Overall, while there were some good practices in place in relation to the monitoring and oversight in the centre, improvements were required in the effectiveness of the auditing system, and in documentation management.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure available to residents and their friends and families. The procedure had been made available in an easy read version and was clearly displayed as required by the regulations. There were no current complaints, however, there was a method of recording and analysing complaints should they arise.

The centre also recorded any compliments, and have received compliments from family members of residents and from neighbours, as discussed in the first section of this report.

Judgment: Compliant

Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. There was a personal planning system in place, although some improvements were required around documentation, and residents were supported to engage in multiple different activities, and to have a meaningful day. Healthcare was well managed for the most part, with some improvement being required to ensure that all required healthcare was followed up in a timely manner.

The residents were observed to be offered care and support in accordance with their assessed needs, and staff communicated effectively with them. Where residents required behaviour support there were detailed behaviour support plans in place which were developed and overseen by a behaviour support specialist. Improvements were required in the management of residents' personal finances to ensure that they did not fall into arrears with any regular payments.

The premises were appropriate to meet the needs of residents, and a newly constructed self-contained apartment and external activities area had improved outcomes for residents.

There were risk management strategies in place, and all identified risks had effective management plans in place. There were systems and processes in place in relation to fire safety, although improvements were required in evacuation times during night time fire drills.

The rights of the residents were well supported, and communication with residents was given high priority. Staff were knowledgeable about the support needs of residents and supported them in a caring and respectful manner.

Regulation 10: Communication

The person in charge and staff members were very familiar with the ways in which residents communicate. This was clear from the observations made by the inspector during the course of the inspection and from discussions with staff.

There was a 'communication passport' in place for each resident which included information about the ways in which they communicated, and the best ways for staff to maximise the understanding of each resident, for example the direction in one passport was to use short, simple sentences.

However, the information relating to the ways in which residents communicate lacked some clarity, for example where it was recorded that residents use vocalisations or gestures, there was no detail as to what each particular gesture meant. Therefore, whilst it was clear that the current staff team, who were familiar with the support needs of each resident and communicated effectively with them, there was a reliance on this knowledge rather than on a documented assessment.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Residents each had their own bank account, and were supported by staff to manage their finances. However, significant improvements were required in the support

offered to ensure that residents were supported to keep their finances up-to-date, and to ensure that safeguarding protocols were adhered to.

The inspector reviewed the finances of two residents, checked the record of both and checked the balance of one of the day-to-day records. While the balance of this account was correct, the inspector found that receipts were not signed by two members of staff as was required by the centre's protocol.

A review of the records, including the bank statements of the other resident found that there were significant bills which had not been addressed in a timely manner, resulting in two back payments totalling over €6 000 having to be paid in January and February 2025. The inspector was not assured that residents' finances were monitored regularly, or that they were supported in a way that ensured they did not fall into arrears.

Judgment: Not compliant

Regulation 13: General welfare and development

There was a clear emphasis in the designated centre on ensuring that residents had a meaningful life, and they were introduced to new opportunities, both in the community and in their home, and significant improvements had been made in ensuring meaningful occupation for each resident since the last inspection.

Some residents went out to jobs or to a day service, and each made their own choice in this regard. Where a resident decided in the morning not to go to their day service, this was respected, and other activities were offered. One resident had a job doing the post for the organisation's office and enjoyed this job.

Some residents had been supported to set goals for achievement, and the goals were broken down into smaller steps towards achievement. Others chose to have a weekly planner, or to make decisions about their activities on a daily basis. Where residents were undergoing changing needs, their routine and activities had been modified accordingly. For example, one resident was no longer able to engage in very active pastimes, and so was supported to enjoy sensory activities and music of their choice, and to enjoy staff company. During the course of the inspection staff were observed to be ensuring the wellbeing and comfort of this resident, who was no longer able to make their needs and preferences known as they once did.

Activities at home included group activities such as the weekly music therapy, and pet therapy whereby a pet dog visited the house once a week. Residents were reported to enjoy these visits, and the person in charge presented photos of residents clearly happily interacting with the dog.

Other residents were supported to have holidays and trips away, and some of these involved their friends who lived in other designated centres operated by the provider, and where residents had moved out to other centres, their friendships

were supported by joint activities and visits to each other's houses.

Overall it was clear that residents were supported to have work and leisure activities of their choice, although as discussed under Regulation 5: Individualised assessment and personal plan, improvements were required in documentation and recording.

Judgment: Compliant

Regulation 17: Premises

The designated centre was appropriately designed and laid out to support the needs of all the residents, each of whom had their own private room. There were various communal areas including living areas and new external cabin for activities. There was also newly constructed self-contained apartment which accommodated one resident, and was in accordance with the agreed actions from previous inspections.

The centre was visibly clean and all areas of the house had been well maintained. It was evident that residents made use of all the communal areas of the house, and that each had their own preferred areas in which to spend time.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a current risk management policy which included all the requirements of the regulations. Risk registers were maintained which included both local and environmental risks, and individual risks to residents which were kept under regular review,

There was a risk assessment and risk management plan for each of the identified risks. Local and environmental risks managed under this system included general security, the management of sharps and the risk of falls. The risk assessment and management plan relating to falls included the requirement for wet floor signs when floors were being washes, and the inspector observed this to be implemented during the course of the inspection.

Individual risk assessments also addressed the risk of falls, and the risk management plan for one resident included control measures such as the use of an alert mat president their bed, and the use of mobility aids. The particular mobility aid had required significant input from the physiotherapist and staff team to ensure that the resident was using it safely.

Other individual risk assessments and management plans included the risks associated with a resident refusing clinical observations, osteoporosis and the risks

associated with dysphagia and the risk of choking.

The inspector was assured that control measures were in place to mitigate any identified risks in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had put in place various structures and processes to ensure fire safety. There were self-closing fire doors throughout the centre and all equipment had been maintained. Regular fire drills had been undertaken, and there was a personal evacuation plan in place for each resident, giving guidance to staff as to how to support each resident to evacuate.

The inspector reviewed the PEEPS for all six residents who were present during the inspection, and found that they included guidance for staff in relation to any difficulties which had been identified. For example, two of the residents had been known to reuse to participate in fire drills. One of them had said that they would evacuate in the event of a real fire, and both PEEPs included reference to the extra supports that each might require. However, not all staff were aware of the guidance in these documents, and not all could describe the assistance that some residents would need in order to evacuate safely.

Regular fire drills had been undertaken and a report of each drill was documented. The reports of daytime fire drill indicated that all residents could be evacuated in under 4 minutes. However, the previous two night time fire drills undertaken in February and March 2025 had each taken over 8 minutes, and did not include the two residents who refused to participate. In addition not all staff had been involved in a fire drill either during the day or under night time circumstances.

During the closing meeting of the inspection the PIC and the Assistant Director of Nursing discussed the use of the compartments in the building, however at the time of the inspection there was no evacuation plan in place which made use of these compartments.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There were personal plans in place for each resident which were regularly reviewed and were based on a detailed assessment of need. The management of the documentation in these personal plans required improvement, as it was unclear in which of the folders belonging to each resident the current care plans were

maintained, and there was duplication of documents in different locations, so that the inspector ws concerned that staff might not have ready access to all the pertinent information. For example, the items relating to care planning and the person centred plan for one of the residents were in three different folders, and were not easily identified.

In addition, whilst it was clear from the observations during the course of the inspection and from discussion with staff and residents that each resident was supported to have meaningful activities, improvements were required in the documentation of these, to ensure that the response of residents was captured, and to facilitate periodical reviews to ensure that standards were maintained.

However, there were clear assessments relating to each resident, including two residents who had been admitted to the centre in recent months. Care plans around specific issues were detailed and provided guidance to staff, for example there was a care plan relating to a resident refusing meals which outlined the response required from staff to manage the issue. Goals and planners had been devised for some residents, but overall this was inconsistent.

Judgment: Substantially compliant

Regulation 6: Health care

Healthcare was well managed for the most part, and each identified healthcare need had a detailed plan of care in place. This included both long term and changing healthcare needs. For example, one resident had a significant change in presentation relating to epilepsy, and there was a detailed plan of care in place relating to the management of the changes, and in relation to maintaining quality of life.

There was an end of life care plan in place for on resident, and the appropriate healthcare professionals had been involved in this plan, including the general practitioner and the palliative care team. The plan had not been signed off as agreed by all the staff team, so that the inspector was concerned that staff might not be aware of the decisions made about the end of life care decisions for this resident should an emergency situation arise.

Staff were vigilant in relation to any changes in presentation, for example staff had noticed changes that appeared to be the symptoms of an ear infection for a resident, so the appropriate referrals were made, and treatment which required a general anaesthetic was provided to the resident, with an excellent outcome.

Residents had access to various members of the multi-disciplinary team, including speech and language therapy, physiotherapy and palliative care, although improvements were required to ensure that any required follow ups were facilitated. For example, a resident required regular chiropody, and it had been agreed that this should be every six weeks, but the last recorded visit by the chiropodist was eleven

weeks prior to the inspection, so that it was not evident that this issue was monitored.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where residents required positive behaviour support, there were detailed plans in place, based on a detailed assessment of needs. These plans were overseen by the behaviour support specialist, and kept under regular review. The plans included guidance for staff at each stage of escalation of any behaviours of concern. The positive behaviour support plan for one resident, whose behaviour was having a significant negative impact on the wellbeing of others, had, together with the provision of more appropriate accommodation arrangements, led to significantly improved outcomes for the resident. The staff and the person in charge spoke about the supports they had put in place, including supporting the resident to have more control and choice in their daily life since the changes had been introduced, which had a significantly positive impact on their quality of life.

Staff had all received training in the management of behaviours of concern, and all staff engaged by the inspector were knowledgeable about their role in supporting all residents, and could identify the strategies in place for each resident.

Where restrictive practices were in place to ensure the safety of residents, they were they were monitored to ensure that they were the least restrictive measures available to mitigate the identified risks. There was a restrictive practices register in place which included each intervention and the rationale for its use.

There was a 'Positive Approaches Support Group' which approved any restrictive practices, and the inspector was assured that restrictions were only in place if they were necessary to safeguard residents.

Judgment: Compliant

Regulation 8: Protection

There was a clear safeguarding policy, and all staff were aware of the content of this policy, and knew their responsibilities in relation to safeguarding residents. Staff were in receipt of up-to-date training in safeguarding, and could discuss the learning from this training.

Staff were familiar with any safeguarding plans in the designated centre, and there was clear evidence that the plans were implemented. A recent safeguarding risk relating to the impact of the behaviour of one resident on others in the house had

been mitigated by the provision of a self-contained apartment for this resident, together with significant positive behaviour supports which had reduced the frequency and severity of any incidents of behaviours of concern.

The inspector was assured that residents were safeguarded form all forms of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were resected and supported in various ways. Residents were making their own decisions and choices in all aspects of their daily lives, including choice of activities, choices of meals and snacks, and ways in which to spend their leisure time.

Where residents were making choices such as vaping, the person in charge and the staff team explained that all the relevant information about the health aspect of the habit were made available to residents, but that they were then supported in their decision to continue to vape.

Significant improvements had been made since the previous inspection in relation to the impact of the behaviours of residents on each other, in particular by the provision of an outside activities area, and a self-contained apartment for one resident, who was now supported to live as independently as they chose, while still having access to the main house and to maintain their relationships with other residents.

The compatibility of residents, and their friendships were given high priority, and where there were vacancies and potential residents were being considered, their compatibility with the current residents had taken priority, and some who had made several visits to the house with a view to moving in had been found not to be compatible, and the transitions had not gone ahead.

Overall it was clear that residents were supported to have a good quality of life, and to have their voices heard.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

There had been transitions both from and into the designated centre since the last inspection. These transitions had been well managed, and the needs and preferences of all residents had been taken into account.

Where residents had moved out of the centre to a more appropriate setting, the transition had been managed in accordance with their needs. There were detailed transition plans which included compatibility assessments followed by a series of visits until the resident was prepared and ready for the move.

The inspector reviewed the transition plan of a resident who had recently moved into the designated centre and found it to be detailed and person centred, and available to the resident in an accessible format. The resident had chosen the décor and furniture for their new room, and had made several visits prior to spending an overnight twice a week until they were ready to make the move into their new home.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant

Compliance Plan for Avalon House OSV-0003694

Inspection ID: MON-0038001

Date of inspection: 04/04/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The 10.00/22.00hrs shift has been reinstated since the week beginning 21/03/2025. This staff line is now consistent on the roster. There are six staff rostered daily. Where there is a shortfall, staff supports are sought within the staff team, regular agency staff and from other areas within the service. Recruitment is ongoing with 2 Care Assistant positions having now been filled from recent recruitment drive. One staff nurse position remains open but same is being worked on by PPIM and DON office to ensure successful recruitment to fill the position.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff Supports have all been scheduled for the year ahead. PIC will ensure all are printed off and signed by each staff and kept on file and that where a supervision is not held on a particular day that same is rescheduled so that all staff supports are carried out within timeframe agreed. A template has been designed to record all staff supervision meetings to facilitate easy oversight and monitoring of dates for frequency and planning of staff supervision meetings	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The annual audit schedule has been reviewed for the service. Prior to inspection a more detailed robust financial audit had been put in place as a result of arrears noted by PPIM and PIC and same are carried out monthly.

PIC has completed an audit of all careplans to ensure no duplication and that all files are as per the index.

Staff meetings are scheduled 4-6 weekly. Once minutes are circulated all staff will be reminded to read and sign same. Once all staff have signed the minutes same will be then filed away. PIC will not file minutes unless all staff have signed off on same.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
Newly developed and approved communication passports have been circulated to staff team with a plan that all will be completed by the end of May 2025.

Speech and language referrals were sent on 22/04/2025 for four residents for a communication assessment. Once assessments received, the new communication passports will be updated to reflect any supports highlighted.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Prior to inspection a more detailed robust financial audit had been put in place because of arrears noted by PPIM and PIC and plan in place to repay same. A more detailed Financial Audit commenced in March 2025 and same will be carried out monthly.
Staff meeting on 30/04/2025 reinforced the need for double signatures on all receipts as

per policy.
Night duty list updated to include checking that all transactions and receipts are signed off by two staff daily.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire drills completed monthly. Discussed at team meeting on 30/04/2025 that all staff are aware and adhere to the details and guidance within each resident's PEEPS.

3 fire compartments are present in designated centre. Compartmental scenarios discussed at team meeting on 30/04/2025. Request for support from the local fire service sought on 17/04/2025 and they are providing ongoing support in regards to compartmental scenarios with a site visit planned for 20/05/2025.

Additional fire drill scenarios are being simulated with a focus on practices to evacuate residents known to refuse to ensure all staff are aware and familiar with the evacuation needs of each resident.

A record is now being maintained to monitor all staff participation in fire drills to ensure all staff have completed and partaken in both a day and night time fire drill scenario.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
PIC has completed an audit of all careplans to ensure no duplication and that all files are as per the index. The folders containing the residents care plans, assessments and documentation to guide staff in their care interventions has been reorgansied to ensure it is easily accesisble for staff.
PIC has completed an audit of person centered plans for each resident. Goals and activity recordings discussed at the staff meeting on 30/04/2025.
New activity recording sheet developed by documentation review group implemented for each resident.
New template in situ to capture in detail quality engagement time with one specific resident.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The end of life care plan was discussed with all staff and at the staff meeting on 30/04/2025. The plan has been read and signed off on by all staff. The Ceiling of Care plan is one of the first documents that is signed on commencement of shift by any new staff.
The chiropodist had visited on the 12/03/2025 and reviewed 2 residents one of which was resident who required regular chiropody. The Clinical notes will be completed by the chiropodist for each visit going forward and the staff nurse on duty will reflect any intervention in a care plan in use and also within nursing notes.

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(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	30/04/2025
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/04/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and	Substantially Compliant	Yellow	30/08/2025

	skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/05/2025
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.	Substantially Compliant	Yellow	30/05/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	30/05/2025
Regulation 05(4)(b)	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	Substantially Compliant	Yellow	30/05/2025

	outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/05/2025