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. Anne's Residential Services - Group G
Name of provider:	Avista CLG
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	20 March 2025
Centre ID:	OSV-0003950
Fieldwork ID:	MON-0044537

About the designated centre

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

In this centre a full-time residential service is provided to four adults. In its stated objectives the provider strives to provide each resident with a safe home and with a service that promotes inclusion, independence and personal life satisfaction based on individual needs and requirements. Residents attend either an off-site day service or receive both a residential and a day service from the designated centre. Transport is available to facilitate day service activities. Residents present with a broad range of needs in the context of their disability and the service aims to meet the requirements of residents with physical, mobility and sensory needs. The premises is a bungalow located on the outskirts of a village. Each resident has their own bedroom. There are communal kitchen, dining and bathroom facilities and a spacious back garden. The model of care is social and the staff team is comprised of social care and care assistant staff, under the guidance and direction of the person in charge. Nursing support and care is also available to the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 20 March 2025	09:30hrs to 16:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken on behalf of the Chief Inspector of Social Services to monitor the provider's compliance with the regulations. In general, the inspector found that the designated centre was well managed. The provider sought to ensure that residents were provided with a safe and comfortable home, enjoyed good health and a good quality of life. However, the provider had itself identified that the needs of this particular group of residents were not best suited to living well together. This absence of compatibility impacted at times on the quality and safety of the service. Controls such as enhanced staffing levels were in place and did reduce the risk of negative interactions occurring between residents. However, the suitability of a resident's placement was a longstanding issue and not yet resolved. In addition, the provider needed to review again the arrangements in place for supporting residents in the management of their personal monies.

Four residents who require support from staff at all times live in this designated centre. The house is a single storey property located on its own spacious site in a pleasant village. Each resident is provided with their own bedroom three of which have ensuite facilities. There is a bathroom located in close proximity to the bedroom that does not have ensuite facilities. Residents share two communal rooms. Residents have access to a secure spacious rear garden and ample parking for staff and visitors is provided.

This inspection was unannounced and the inspector found the house to be pleasant and welcoming, visibly clean and in good decorative order. Resident's bedrooms were nicely presented and personalised with for example, family photographs. The assessed needs of the residents included behaviours of concern. The use of murals throughout the house enhanced the overall presentation of the house where wall-hangings could be challenging for a resident to tolerate. Externally, the grounds and house were well-maintained.

When the inspector arrived there was one resident in the designated centre and one staff member. The staff member advised the inspector that two staff members had left with the other three residents to go to the day service. These three residents attended an off-site day service Monday to Friday. The fourth resident received a wrap-around type service in the designated centre where the residential staff supported a programme of activities for the resident. The inspector did not have the opportunity to meet with the residents who attended to day service as they had not returned from the day service prior to the conclusion of this inspection.

The staff member on duty advised the inspector that the resident who remained in the designated centre could be protective of their personal space. However, the resident smiled and took the inspectors hand very gently when greeted and when spoken with at intervals during the day. All four residents living in the designated are non-verbal communicators.

Shortly after the inspector arrived the person in charge who was on duty in a nearby designated centre came to facilitate the inspection. The two staff members who had accompanied the residents to the day service also returned. There was a pleasant atmosphere in the house as staff discussed the handover of certain tasks, the plans for the day and attended to household tasks. Staff reported that they liked working in the centre and said they had good support from management and from their peers.

Staff told the inspector that they were happy with the staffing levels and said these levels were consistently maintained by the provider. Staff were comfortable with the presence of the inspector in the house and competently described arrangements such as the controls in place in response to the absence of compatibility between the residents. A member of the senior clinical nurse management team (a CNM3) also came to the designated centre and discussed with the inspector for example, the provider's response to the last Health Information and Quality Authority (HIQA) compliance plan.

The inspector did not meet with any resident representatives. However, the inspector saw from the report of the most recent annual quality and safety review that feedback from families had been sought as part of the review. The response rate was low with one family providing feedback. That feedback was very positive. Staff did maintain a log of contact with families. That contact was regular and families were kept informed for example of any changes or incidents that occurred. Families could visit the centre and residents were supported to visit family and home.

Staff had also supported residents to provide feedback to inform the annual review and had reported on behalf of residents that it was difficult for two residents in particular to live together.

Staff spoken with described how the resident who was in the designated centre needed encouragement from staff to be active and engaged but always left the designated centre willingly with staff. The weather was very pleasant on the day of inspection and the resident left the designated centre twice with staff to visit recreational amenities where they enjoyed a walk with the support of staff and a wheelchair. The resident had a personal plan and from that plan the inspector saw that goals and objectives were set and progressed so that the resident experienced and enjoyed new opportunities such as travelling on a train. However, the residents routine was different to the other residents and records seen by the inspector did not provide assurance that that routine of late, was fully consistent with all aspects of the residents plan specifically their nutritional and healthy eating plan. This finding was relevant to the last HIQA inspection findings as the deviation from the nutritional plan was evidenced by the inspector from the resident's financial records. In that regard, the provider needed to review and address again how it maintained oversight of and ensured that the improvement that was previously needed was consistently maintained.

In summary, this was a good service but the provider itself knew that there was an absence of compatibility between residents that, while managed, did still impact at

times on the quality and safety of the service. The provider had a plan to provide a resident with their own single-occupancy service to address this but this was a longstanding plan and had not yet materialised.

The next two sections of this report will describe the governance and management arrangements in place and how these arrangements ensured and assured the quality and safety of the service.

Capacity and capability

There was a clear management structure in place that operated as intended by the provider. There was clarity on roles and responsibilities. However, the provider had a longstanding plan that was not yet delivered to provide one resident with a service better suited to their needs and preferences.

The day-to-day management and oversight of the service was delegated to the person in charge. The person in charge had support from a lead staff member, the house manager. There were duties and responsibilities delegated to the house manager and to the staff team. However, it was evident from speaking with the person in charge and from records seen that the person in charge was actively and consistently engaged in the management and oversight of the service. For example, while there were nominated keyworkers the person in charge was actively involved in the planning meetings and in the review of each resident's personal plan.

The person in charge had responsibility for another designated centre and had an office in that designated centre. The person in charge was available as needed and called at least twice each week to the designated centre. The person in charge confirmed they had ready access and support from the clinical nurse management team and the director of services.

The staff duty rota was well-maintained. Staffing levels, staffing arrangements and staff skill-mix were suited to the assessed needs of the residents including the risk arising from the absence of compatibility between the residents. Good oversight was maintained of staff attendance at training.

Systems of quality assurance included regular reviews of areas such as the management of medicines, infection prevention and control, fire safety and, the review of incidents, risks and how they were managed. In addition, the annual review referred to in the opening section of this report had been completed as were the quality and safety reviews required by the regulations to be completed at least every six-months. These reviews were, based on records seen, completed on schedule and reviewers found that quality improvement plans were satisfactorily progressed. The director of services completed some of these quality and safety reviews and also called to the designated centre which meant that management at a senior level had a presence in the designated centre, met with staff and residents,

directly observed and evaluated the service and the support provided to residents.

The providers own systems of quality assurance acknowledged that the provider had yet to implement its plan to resolve the absence of compatibility between the residents. Records seen by the inspector reported that the timescale was now extended from 2025 to 2026.

Regulation 14: Persons in charge

The person in charge worked full-time. The person in charge had the experience, skills and qualifications required for the role. The person in charge was person in charge for another designated centre and was satisfied they had the capacity and the support they needed to ensure the effective governance and operational management of the designated centre. The person in charge could describe and demonstrate to the inspector how they planned and maintained oversight of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels, staffing arrangements and staff skill-mix were responsive to the needs of the residents. The staff duty rota was well presented and showed each staff member who worked in the centre, their role and the hours that they worked. The staffing arrangements on the day of this inspection were as outlined in the duty rota. The staff team skill-mix included a nursing staff and additional nursing advice and support was available from the clinical nurse managers (CNM) and a number of clinical nurse specialists (CNS).

Staff spoken with were satisfied with the staffing levels and arrangements and their ability for example, to implement safeguarding strategies such as supervision and different activities for residents. Based on the rota reviewed by the inspector there was a minimum of three and at times four staff members on duty each day up to 20:00hrs. The night duty staffing arrangement was a staff member on waking duty and a staff member on sleepover duty.

Staffing arrangements considered the requirement for and ensured continuity. This was evident from the previous and current staff duty rotas reviewed by the inspector. The staff spoken with had established service in the designated centre and staff members who had the capacity to do so worked additional shifts that arose.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the staff training matrix and saw that there was a good system in place for ensuring staff completed mandatory, required and desired training and, completed refresher training. The training matrix indicated that all staff had completed training in for example, safeguarding residents from abuse, responding to behaviour that challenged including de-escalation and intervention techniques and, fire safety. Refresher training, was scheduled or booked. There were no concerning gaps in staff attendance at either baseline or refresher training and the person in charge was aware of any training that needed to be rescheduled.

Additional training completed by the staff team included a broad range of infection prevention and control training and training such as in the assisted decision making act.

The provider had a system for ensuring all grades of staff were formally supervised and these systems were implemented in the designated centre. For example, the CNM provided supervision for nursing staff, the person in charge completed supervision with the house manager who in turn completed supervision with the frontline staff team. The person in charge described how systems of supervision including probationary reviews were used to support staff. A staff member spoken with confirmed they had completed probationary reviews. The inspector noted that the provider led reviews monitored and ensured that formal staff supervisions were taking place.

The person in charge held regular staff team meetings. The inspector read the most recent minutes and noted good discussion of matters such as residents changing needs and safeguarding plans. Staff not present at the meetings signed to confirm they had read the meeting minutes.

The inspector saw that copies of the Act, the regulations and other relevant guidance such as guidance on respecting and promoting residents human rights was available in the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

Overall, there was much evidence of good and consistent management and oversight and the governance structure operated as intended by the provider. For example, the director of services directly inputted into the systems of quality assurance, the CNM attended staff meetings, the person in charge had an active

presence in the centre and staff spoken with were clear on their roles and duties. However, the provider had a longstanding plan to provide a resident with a service better suited to their needs. The provider knew and acknowledged that the absence of compatibility between residents impacted on the quality and safety of the service. While responsive controls such as enhanced staffing levels were in place the plan to transition the resident to another service was longstanding. For example, the plan was referenced in the findings of the last HIQA inspection and was a repeat action from the providers own internal reviews. Records seen by the inspector stated that the timescale was extended from 2025 to 2026.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose and function was available in the designated centre. The inspector read the statement of purpose and saw that it had been updated to reflect changes such as to the management structure. The statement of purpose contained all of the required information including the number of residents who could be accommodated, the range of needs that could be met and arrangements such as how to make a complaint.

Judgment: Compliant

Quality and safety

This was a well managed service where the care and support provided was individualised to the assessed needs of each resident. Residents received the care that they needed to stay well and healthy and to have a good quality of life. However, the provider itself knew that the designated centre was not suited to the needs and preferences of one resident. The provider had a longstanding but unresolved plan to provide the resident with a service better suited to their needs. In addition, better systems were needed for maintaining oversight of all meals provided for residents including meals financed by residents own monies.

Each resident participated in the process of personal planning. The inspector followed a particular line of enquiry and reviewed one resident's personal plan. The plan was person centred, was based on the assessed needs and preferences of the resident and included the goals and objectives to be achieved with the resident. Staff maintained a record of how these goals were achieved and whether the resident had enjoyed and benefited from the particular activity. The care and support provided was informed and reviewed at regular intervals by the wider multi-

disciplinary team (MDT).

The personal plan included identified healthcare needs and the care to be provided so that the resident enjoyed the best possible health. Records confirmed that the resident was supported to access as needed the clinicians and services they needed. For example, the general practitioner (GP) and if necessary out-of-hours medical services.

The plan included a nutritional plan. The plan set out the goal of providing the resident with a healthy, varied low-fat diet and healthy food choices. However, records seen including the residents financial records and the daily notes completed by staff indicated that the support provided to the resident was not fully consistent with the nutritional plan. The records indicated a recent pattern of the regular consumption (eight occasions in a recent two week period) of convenience foods while out and about in the community with staff.

The resident did not have the capacity or the ability to purchase these meals themselves and the meals were paid for by staff using the residents own monies. The additional matter to be considered by the provider was the pattern of the spending of the resident's monies.

The person in charge maintained and kept under review a register of the risks that presented in the designated centre and how they were managed. Incidents were recorded, reported to management and reviewed by the person in charge. Incidents were discussed at the staff team meetings and actions taken in response to incidents such as falls included further referral to the MDT.

One of the risks that presented in the centre was the risk for behaviour of concern that had the potential to impact on the quality and safety of the service. For example, there were behaviours that could be directed at peers and behaviours that had a more generalised impact such as vocalisations and property damage including the personal possessions of peers. This meant that there were restrictions and safeguarding plans in place. Staff spoken with had a good understanding of these plans and described how the staffing levels in place supported supervision, different routines and activities for residents. These arrangements helped to reduce the risk of negative peer-to-peer incidents. However, incidents did still happen and ultimately the provider needed to progress the transition plan.

The restrictions in place were of an environmental nature. For example, all resident's wardrobes were locked to protect their personal possessions. The inspector noted that items such as the televisions were behind protective screens and the person in charge confirmed that residents did not have access to the remote controls. This was not identified as a restrictive practice. The person in charge was requested to bring this practice to the attention of the restrictive practice committee.

The inspector saw that the house was fitted with the required fire safety measures. There was documentary evidence in place that these measures were visually inspected by staff and inspected and tested at the required intervals by externally contracted persons. Regular simulated drills were undertaken to test the evacuation

procedure.

Regulation 10: Communication

As stated in the opening section of this report the assessed needs of all of the four residents included communication differences. There was a communication passport in the personal plan reviewed by the inspector. The passport set out how the resident communicated what it was they wanted or needed such as their use of facial expressions or guiding staff to what it was they wanted. The passport also provided guidance for staff on how to communicate effectively with the resident. For example, using short sentences or showing the resident items or objects of reference. Staff spoken with understood the use of behaviour by residents in communicating needs and preferences.

Judgment: Compliant

Regulation 11: Visits

As appropriate to their individual circumstances residents were supported to maintain contact with family and home. These arrangements were different for each resident. There were no restrictions on visits. Staff maintained a record of these visits and of all contact they had with families.

Judgment: Compliant

Regulation 12: Personal possessions

Improvement was noted in the oversight of the management of resident's personal monies. The person in charge and the CNM3 outlined for the inspector the actions taken by the provider in response to the last HIQA inspection findings. Those findings referred to the inadequate oversight of the spending of resident's monies and the purpose for which the monies were spent. The actions taken by the provider in response included education and training for the staff team from the MDT, financial audits completed locally in the centre and also by the centralised finance department. The inspector was advised that there had been discussion with and clarity for staff on the purposes for which residents monies could be used.

The inspector saw records of financial reviews completed by the financial department and records of the monthly oversight completed by the person in charge. The inspector saw that each resident had a financial ledger in which records of credits and debits were recorded and an index was provided of the supporting

receipt. The inspector followed certain recorded expenditures largely dependent on where the money was spent and the amount of money spent. The inspector saw that there was a corresponding receipt in place for each recorded spending. However, there was a recent pattern of spending for one resident that was different to the other residents as the resident had a different daily routine. The records of concern were recent and had yet to be reviewed by the person in charge who reviewed the ledgers on a monthly basis. The resident did not have an adequate understanding of money to manage their own finances and was fully supported by the staff team in this regard. The records demonstrated a recent regular pattern of spending on convenience take-away fast foods while out and about in the community with staff. While this spending was accounted for the pattern of spending indicated that this was an area that needed to be revisited again by the provider as the records reflected recent slippage. In addition, the actions the provider said it would take to prevent a reoccurrence included reconciliation of the weekly meal planners with the record of the actual meals provided and consumed. There was no one concise record of the latter in place as described in Schedule 4 of the regulations. This left a gap in the providers system of oversight and quality assurance.

Judgment: Substantially compliant

Regulation 17: Premises

The designated centre was suited to the assessed needs of the residents. The centre was well-maintained externally and internally. The house was bright and welcoming, visibly clean but homely and in good decorative order. Each resident was provided with their own bedroom three of which had ensuite sanitary facilities. Residents had a choice of shower and bathing facilities and staff spoken with described how some residents had a preference for and enjoyed using the bath. The location of the house meant that residents could enjoy walks in the village with staff support. Residents also had access to a spacious secure rear garden with a swing.

Judgment: Compliant

Regulation 18: Food and nutrition

Better systems were needed for ensuring that residents had choice but also received support that ensured their diet and the meals provided were wholesome and nutritious. The inspector saw that there was a weekly meal planner and residents were supported to eat out or to enjoy a takeaway meal once a week. Nutritional plans were advised with input from a dietitian and speech and language therapy where residents required modification of the texture of their food so that they could eat safely. On the day of inspection the inspector saw the staff freshly prepared the

main evening meal. The CNM3 and the person in charge confirmed that they regularly observed staff prepare the main meal that was planned in the weekly meal planner. However, as discussed in the management of resident's finances the financial records of one resident indicated a recent pattern of spending on convenience fast foods at lunch time. This was not in line with the resident's healthy eating plan. The inspector was advised that there was no particular challenge to supporting the resident to make good dietary decisions while also enjoying occasional treats. As discussed in regulation 12 a record of the food and meals provided, in detail that was sufficient to determine and provide assurance that the residents diet was satisfactory and in line with their nutritional plan was not in place.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the identification, management and ongoing review of risk. This was evident from the risk register and discussion with the person in charge. There was a system in place for recording, reporting and reviewing incidents and accidents and for sharing any learning with the staff team. The risk assessments seen by the inspector reflected what was discussed such as the risk for peer-to-peer incidents and the risk for falls. The controls to manage these risks included MDT review and specific plans such as for falls prevention and positive behaviour support.

Judgment: Compliant

Regulation 28: Fire precautions

Good oversight was maintained of the designated centres fire safety arrangements. For example, there was documentary evidence in place of the inspection and testing at regular intervals of the fire detection and alarm system, the emergency lighting and fire-fighting equipment. The actions to be taken in the event of a fire and details of the evacuation routes were prominently displayed. In addition, oversight was maintained of the effectiveness of the simulated drills to ensure they were completed to reflect different scenarios and to ensure good evacuation times were achieved. Each resident had a personal emergency evacuation plan (PEEP). The four drill records reviewed by the inspector were comprehensively completed by staff, reported that all residents co-operated with the evacuation procedure and staff and residents vacated the centre in good time.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs of residents was completed and individualised personal plans were developed based on the findings of the assessments. Each resident had a key-worker. The person in charge and the provider (for example during the provider-led reviews) monitored the implementation and maintenance of the personal plans. The inspector reviewed one resident's personal plan. The plan was person-centred and reflected the care and support needs that had been discussed with the inspector. Family were invited to participate and input into the development of the personal plan. Staff sought to maximise the participation of the resident in the development and review of their personal plan. There was documentary evidence of regular MDT input and review. The resident's personal goals had been agreed at the most recent annual planning meeting and staff maintained a record of how goals were progressed and achieved.

The provider had concluded that the designated centre was not suited to the needs of one resident. This and the progression of the plan to address the unsuitability is addressed in Regulation 23: Governance and management.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident health and well-being and sought advice and care when they had concerns, for example, from the on-call CNM team. The person in charge ensured that residents had access to the healthcare services that they needed such as their General Practitioner (GP), out-of-hours medical review and care, psychiatry, hospital based services and clinicians and, the MDT as appropriate to their needs. The inspector saw records of reviews and recommendations made by for example, speech and language therapy, physiotherapy, the dietitian and occupational therapy. Healthcare plans included plans in relation to falls prevention and safe eating and drinking. A staff member spoken with had a good understanding of a plan in place for the administration of an emergency rescue medicine.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were times when residents exhibited behaviour of concern. The behaviour of concern did not result solely from the absence of compatibility between residents. For example, staff described how one resident had a longstanding history of being intrusive with property and items that were not their own. Residents had access to

psychiatry, psychology and the clinical nurse specialist in positive behaviour support. Positive behaviour support plans were in place to guide staff on the type of behaviour that could present and the preventative and responsive strategies in place. These strategies included the supervision, redirection and different routines described elsewhere in this report. A staff member spoken with described the importance and benefit of having a regular team of staff as staff were aware of cues that could be a precursor for behaviour of concern.

Restrictions were in place such as the securing of the rear garden and the locking of residents' wardrobes so as to protect their personal items. There was a risk based rationale for the restrictions in use and systems for reviewing their ongoing use and impact.

Judgment: Compliant

Regulation 8: Protection

Residents did not always live well together in this designated centre and further action by the provider was needed to ensure that residents were at all times protected from harm including harm from a peer. Safeguarding controls were in place. For example, the provider had reduced the occupancy of the house and had increased staffing levels so as to provide better support and supervision. There were plans in place to safeguard residents and these safeguarding plans were a standing agenda item at staff meetings. Staff spoken with had good knowledge of the risk and the plans. Incidents were recorded, reported to the designated safeguarding officer and to the Chief Inspector of Social Services. However, the risk for incidents to happen particularly between two of the residents required vigilance and consistent management by the staff team. Incidents also occurred that were not specifically directed at peers but could impact them such as raised noise levels in the house. To ensure the protection of all residents the provider needed to progress its plan to provide a resident with a service better suited to their needs and preferences. This outstanding safeguarding action is addressed in Regulation 23: Governance and management.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for St. Anne's Residential Services - Group G OSV-0003950

Inspection ID: MON-0044537

Date of inspection: 20/03/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider continues to collaborate with an approved housing body (AHB) and the funding authority in relation to the provision of a suitable individualized home for one individual. The provider continues to raise the bespoke need of the individual at Admission Discharge and Transfer committee meetings. Assurances have been received from the Approved Housing Body that stage one and two have been passed successfully in relation to the property retrofit for the individual and stage three was submitted for approval 21/03/2025. Once stage three has been approved, the work to be carried out will go to tender. In the interim, the person in charge and provider will ensure ongoing monitoring of safeguarding issues and maintain an individualized bespoke timetable for this individual to meet his specific needs and those of the wider group. As of today's date, (14.04.25) and for some time, all safeguarding in this house is closed to the HSE safeguarding committee.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: Since the inspection, the staff team have been met by the PIC & PPIM (28/03/2025) in relation to the money spent on behalf of the resident on fast food takeaway. The provider has linked with the Speech and Language therapist to support the team with preparing suitable modified nutritious meals. The staff team will offer the residents a suitable meal choice menu which will be reviewed weekly by the PIC. Staff will continue to ensure that the residents' monies are spent appropriately and accounted for in their ledger, in line with the finance policy and in line with reflection of appropriate	

expenditure in a balanced and appropriate manner.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: Since the inspection the PIC has put in place a dietary intake journal for staff to record daily intake of foods eaten, offered and refused by the residents with specific dietary plans. The staff team were met on 28/03/2025 and informed of the need to adhere to the recommendations of the dietician and the FEDs plans designed by the Speech and Language Therapist. The provider has spoken with SLT who will support the staff team with specific menus in relation to the corresponding FEDs plan in terms of quality and texture. These menus were sent to the area (08/04/2025) for their use and to promote a healthy safe diet for the residents.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	30/04/2025
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered	Substantially Compliant	Yellow	30/09/2026

	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.			