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:	SVC - AG
Name of provider:	Avista CLG
Address of centre:	Dublin 7
Type of inspection:	Unannounced
Date of inspection:	14 August 2026
Centre ID:	OSV-0004021
Fieldwork ID:	MON-0045359

About the designated centre

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

SVC-AG provides full-time residential care and support to adults with intellectual disabilities who are of an aging profile and who have complex medical presentations with multiple comorbidities. SVC-AG is located within a campus setting in a residential area of a city and is close to local shops and other amenities such as cafes, public houses and a swimming pool. The centre comprises of three bungalows. The communal facilities in each bungalow are of a similar layout with residents having access to an open plan communal area which incorporates lounge, kitchen and dining room facilities. The open plan area in two of the bungalows also provides direct access to rear gardens with covered seating areas. The third bungalow does not have a rear garden, although a front garden is provided again with a covered seating area for residents to use. The bungalows have two toilets as well as a communal bathroom with an additional toilet facility as well as an accessible walk-in shower and adapted bath. A further smaller sitting room is provided in each bungalow to enable residents to meet their friends and family in private. Residents are supported in each bungalow by a staff team which comprises of nursing, care and household staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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
Friday 14 August 2026	09:00hrs to 17:30hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This unannounced risk based inspection was carried to monitor the provider's ongoing compliance with The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Overall, the inspection showed that the residents living in the centre were in receipt of a quality and safe service from a dedicated and competent staff team. Some improvements were identified as being required in staffing, premises, resident care plans and fire safety. These are discussed in more detail later in this report.

The designated centre is located on a campus based setting in Co. Dublin. The centre consisted of three bungalows that were registered to accommodate up to eighteen residents. On the day of this inspection, the provider had three resident vacancies. The provider had, prior to this inspection, submitted an application to vary the footprint and reduce resident numbers in the centre. This application was in progress on the day of inspection.

The bungalows were all similar in layout. Each bungalow had six resident bedrooms, three accessible bathrooms, an open plan living and dining space, fully fitted kitchens, a nurses' station, laundry and sluice rooms and an area for staff to store personal belongings.

On the day of this inspection, the person in charge and clinical nurse manger 1 (CNM1) were on leave. The inspection was facilitated by the person participating in management and staff working in each of the bungalows. The inspector had the opportunity to meet with and speak to residents in each part of the centre, front line staff in each house and the family member of one resident who was visiting on the day of the inspection. Judgements on regulations were formed by the inspector through observation of the interactions between residents and staff and a review of key documentation.

On arrival at the centre the inspector was met by a member of the front line staff team who conducted a walk around of the first bungalow. The inspector moved to each of the bungalows and completed a walk around with members of the staff team. The inspector observed that in each bungalow residents had their own bedrooms that were individually decorated to each resident's choosing. The inspector observed some of the fire doors in two of the three bungalows were wedged open. The inspector also observed some issues with storage and damage to door frames and walls in the centre. These are discussed in greater detail in Regulation 17: Premises of this report. The inspector observed that the centre were laid out to meet the assessed needs of residents. Each bungalow was warm and

homely and the inspector observed a positive atmosphere in each of the residents homes.

Residents told the inspector they were happy in their homes. One resident who met with the inspector spoke positively about the staff team and the activities they participate in. The resident also told the inspector that they were happy with their bedroom and that they could use their room as they wished without disruption or question from staff. Residents who used non-verbal communications appeared happy and comfortable to the inspector. Residents used a mix of body language and gestures to indicate to the inspector that they were happy. The inspector observed that all residents appeared to be entirely comfortable in the presence of the staff team. The inspector observed in each bungalow a positive, friendly and homely atmosphere with staff responding to residents' needs.

The inspector met with a family member who was visiting a loved one. The family member told the inspector that they were very happy and satisfied with the service provided. The inspector was told that staff will share information as needed with the resident's consent. The inspector was told that the resident had a very active social life. The resident's family can visit as they wish and when they do visit they are always happy with the resident's appearance and general demeanour. The inspector observed that all residents appeared to be healthy and each wore appropriate clothing for the time of year and weather.

The inspector spent time observing and listening to interactions in each of the bungalows. Staff were heard and observed to be attentive to the residents' needs. Staff engaged with residents in a person-centred and warm manner throughout the day. The inspector observed residents coming and going from each bungalow with staff throughout the inspection. The inspector observed residents in communal areas of each bungalow enjoying and comfortable in each others presence.

Staff who met with and spoke to the inspector were knowledgeable in terms of what was required to meet the assessed needs of the residents. Staff were also aware relevant reporting mechanisms and on-call arrangements if the person in charge or CNM1 were not present in the centre.

The next two sections of this report will outline in greater detail the provides capacity and capability to operate the day-to-day tasks of the centre and the impact these systems had on the quality and safety of the lived experiences of the residents.

Capacity and capability

This inspection showed that the provider had the capacity and capability to oversee the day-to-day operations of the centre. Improvements were required in terms of Regulation 15: Staffing, to ensure a greater continuity of care for residents through

the use of familiar staff and to ensure that all staff working in the centre are identifiable on rosters.

The provider had ensured the centre had an effective management structure with a person in charge reporting to a person participating in management. Effective systems were observed regarding the oversight and auditing of the centre. The staff team had been in receipt of appropriate mandatory and centre specific training to meet the needs of the residents. Systems were also in place regarding the booking of relevant training. Centre management also ensured staff had been in receipt of professional supervision.

The provider maintained a comprehensive directory of residents that met the requirements of the regulations. The provider also had a detailed statement of purpose the clearly outlined the purpose and functions of the centre also in line with the relevant regulation.

Regulation 15: Staffing

While the provider had an adequate skill mix of staff to meet the assessed needs of the residents, there was a consistent use of agency and relief staff that impacted on the continuity of care provided to residents.

On the day of this inspection, the provider had vacancies at care staff grade and staff on long term sick leave. The provider's contingency plan for planned and unplanned leave consisted of relief staff, agency staff and permanent staff working additional hours. The provider had actual and planned rosters in each centre. Rosters were maintained by the person in charge as part of their oversight responsibilities. The inspector reviewed rosters in the centre from June and July 2026 and observed the following:

- the centre was staffed with a mix of nursing staff and care assistants
- day shifts worked by staff were 07:40-20:15, 08:00-17:30 and 08:00-20:00
- waking night duties worked were 20:00-08:00

The inspector observed in each week reviewed that agency and relief staff were used. While it was evident that the provider attempted to use consistent staff it was not always possible. For example, in one week reviewed in June 2026, eight vacant shifts were covered with five different staff covering shifts. In a week in July 2026, eight vacant shifts were covered with six different staff covering shifts.

In addition, where agency and relief staff were used, they were not always identifying if they were agency or relief. In the case of agency staff, they were not always identifying what agency they came from. This meant that the provider could not always provide a continuity of care to residents or effectively track agency usage according to centre rosters.

Staff who met with the inspector showed a strong knowledge of the systems used by the provider and of key assessments and plans required to meet the residents needs.

In summary, the provider had a sufficient skill mix in the centre but the inspector observed a weekly reliance on agency and relief staff. The provider was required to ensure that all additional staff working in the centre are identifiable on weekly rosters to ensure a greater continuity of care and tracking of agency use.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had ensured that all staff working in the centre had completed mandatory and centre specific training that ensured that the staff team had the required knowledge and skills to effectively meet the assessed needs of the residents.

The provider had a training log that evidenced the mandatory, centre specific and refresher training completed by the staff team. The training log was reviewed on a regular basis by the person in charge as part of their oversight responsibilities.

The inspector reviewed the training log and observed that the staff had completed training in areas such as:

- fire safety
- food safety
- infection prevention and control
- safeguarding
- manual handling
- human rights
- managing eating, drinking and swallowing in people with intellectual disability (FEDS)

The inspector also observed that when required the staff team where scheduled to complete refresher training. For example, the inspector observed staff had refresher sessions scheduled for manual handling and hand hygiene.

The provider had also ensured that the staff team had been in receipt of professional supervision in line with the provider's policy. The inspector observed a supervision schedule in place for 2026 and reviewed a sample of the supervision records maintained by the person in charge.

The inspector observed supervision sessions with agenda items including a general check in, specific goals, training and care plans. Staff who met with the inspector

were complementary of the supervision process and with the supports from the centres management team.

Overall, the provider had systems in place to ensure staff were in receipt of all training required and ensured that staff were appropriately supervised in line with policy.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had ensured that a directory of residents was available in the designated centre which met the requirements of the regulations. The inspector reviewed the directory of residents on the day of this inspection.

In reviewing the directory of residents, the inspector observed that it contained accurate and up-to-date information on the residents living in the centre. For example, information was available regarding the dates of the residents' admission to the centre, time they have spent away from the designated centre, contact details of family members and, of the residents' general practitioner (GP).

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured that there was a robust governance structure in place with clearly defined roles for each level of management in the centre. The provider also had a number of audits and meetings that ensured the provider was continually aiming to improve service provision.

The centre was managed day-to-day by a suitably qualified and experienced person in charge. The person in charge was supported day-to-day by a clinical nurse manager one and the person in charge reported to the person participating in management.

The systems used by the provider to monitor and audit the centre included an annual review, provider led unannounced audits every six months, governance meetings, team meetings and local audits. On the day of this inspection, the inspector reviewed documentation from all of the aforementioned systems. The inspector observed that meetings and audits had corresponding action plans with the person responsible for completing and time line for each action clearly identified. In reviewing meetings held in the centre, the inspector observed agenda items to include key topics such as:

- risk management
- safeguarding
- resident updates
- training
- incident reviews

In reviewing the agreed action plans from meetings and audits in the centre, the inspector observed a range of actions including risk assessment reviews, schedule staff training, improvements in resident goal setting, scheduling of multi-disciplinary team meetings for residents and, staff to update resident care plans.

The inspector observed that actions identified had either been completed or a time line was in place for actions to be completed. This showed that systems were in place to highlight areas of concern and for those areas to be addressed in a timely manner.

In summary, the evidence gathered by the inspector showed a robust and defined governance system. Additional provider led systems were in place to identify further areas of improvement which were acted upon in a timely manner.

Judgment: Compliant

Regulation 3: Statement of purpose

On the day of this inspection the inspector reviewed the centres statement of purpose and observed it clearly outlined the care and support provided to residents, as well as the day-to-day operations of the centre.

The inspector observed that the statement of purpose was available to all stakeholders in the centre and in an accessible format for residents.

In addition, the inspector completed a walk around of the centre and observed that the statement of purpose accurately reflected the layout and purpose of each of the rooms.

Judgment: Compliant

Quality and safety

Overall, the inspection showed that residents in the centre were supported in a safe environment living a high quality of life that was rights based.

Improvements, however, were identified as being required regarding the upkeep and storage arrangements of the centre. Mobility aids were found to be stored inappropriately, damage was observed to walls and door frames and some areas of the centre were cluttered.

The inspection also showed improvements were needed regarding some fire safety practices, namely, the wedging open of fire doors and the weekly activating of the centre's fire alarm.

Residents in the centre were supported as much as possible to enjoy a meaningful day and strong relations were maintained with family and loved ones in line with resident wishes. Residents had access to a range of food items with comprehensive feeding, eating, drinking and swallowing (FEDS) plans in place to support staff.

Care plans reviewed by the inspector did require some improvements to ensure they gave staff clear guidance and rationale for actions as well as ensuring care plans were audited for their effectiveness.

The provider had ensured adequate systems were in place regarding risk management in the centre.

Regulation 13: General welfare and development

This inspection showed that residents living in the centre were being supported with a meaningful day and had activities of their choosing provided.

Residents in the centre had planning meetings that were attended in person by the resident, staff working in the centre including management and the residents family members. Goals and activities were planned with the residents involvement. As goals were being implemented this was documented on a tracking form with photographs of the residents engaging in the planning and participating in goals.

The inspector reviewed residents person centred planning folders and observed evidence of residents participating in a wide variety of activities including visiting museums, holidays both abroad and in Ireland, attending theatre shows and festivals and, spa days. Key information was available to staff regarding what the resident likes, dislikes, who they are and the background they came from.

Residents were supported to have meaningful contact with loved ones and friends as they wished. The inspector observed residents participating in family celebrations such as christenings and birthday parties. On the day of this inspection one of the residents had a visit from a family member.

The inspector also observed a goal for one resident regarding the refurbishing of the garden in one of the centres. On the day of this inspection the inspector observed

that the refurbishing had been completed and the residents in the centre were enjoying the sunshine in their new garden.

Judgment: Compliant

Regulation 17: Premises

The provider had ensured that each of the homes that made up the designated centre was laid out to meet the assessed needs of the residents and each bungalow was clean. However, repair works were required in each bungalow and the inspector observed a number of storage issues that led to rooms being cluttered.

The inspector completed a walk around of each of the bungalows and observed that each resident had their own bedroom. Resident bedrooms were decorated to residents individual style and preferences. The inspector observed personalised items such as family photographs and soft furnishings. Where required, residents had aids to support their mobility such as tracking hoists in their bedrooms.

The inspector observed residents using all areas of their homes freely as they wished. The inspector observed residents relaxing together in communal areas of their home such as dining rooms and the garden.

The inspector did observed a number of areas that required repair and items that were inappropriately stored due to a lack of sufficient storage. The inspector observed door frames and skirting boards throughout that had been damaged by resident wheelchairs. On the day of this inspection, there was not a plan in place to replace or repair damaged door frames and skirting boards.

The inspector observed that in one sluice room, the provider had stored a number of commodes and wheel chairs. This meant that the sluice room could not be used as intended as the mobility aids were blocking access to the room. The inspector also observed that in a family room the provider had stored archive boxes, wheel chairs, nebuliser machines and multiple boxes of personal care items. This meant that residents could not use the family room comfortably for its intended purpose due to the items inappropriately stored.

Overall, the inspection showed that while each of the homes were clean and residents had access to aids and supports in line with assessed needs, there were a number of maintenance and storage issues that required action from the provider.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The provider had adequate systems in place to ensure the centre had supplies of food. Staff were also guided on residents' assessed feeding, eating, drinking and swallowing needs through comprehensive plans drafted by members of the provider's speech and language team.

The inspector reviewed the food items available to residents, the storage arrangements and a sample of resident care plans on the day of this inspection.

The inspector observed that residents had access to a wide range of food items including dairy products, fruits, vegetables, breads, dried foods such as cereals, tinned foods, snacks, teas and coffees.

The inspector was told that residents in each centre required their foods to be modified. The inspector reviewed a sample of residents feeding, eating, drinking and swallowing (FEDS) plans. The plans reviewed were comprehensive and guided and supported staff to ensure residents were supported with a positive mealtime experience.

Guidance was available on what the assessed consistency of foods and drinks should be and what foods and drinks should present as if they have been modified appropriately. Staff were informed of what foods each resident should avoid and the plans clearly stated the guidance applied to all settings where food is served.

Staff were informed on staffing levels required, positioning of residents and the optimum environmental settings for each resident. The plans also guided staff on what to look out for that would require the meal to stop and also when referrals would need to be submitted. In the event a resident required their plan to be reviewed, speech and language therapy was available on site in the provides newly refurbished multi-disciplinary team (MDT) building which the inspector also visited.

The inspector also observed that staff had completed the required FEDS training that allowed them to safely support residents with their assessed needs.

In summary, residents had access to wide variety of foods and drinks. The provider had also ensured that staff were trained appropriately and that comprehensive plans were available to staff to ensure residents enjoyed a safe and positive meal time experience.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had effective systems in place to identify, assess, mitigate and review risk management in the centre.

The provider had a risk management policy in place that guided staff practice in the area of risk management. The provider had a risk register in place for each resident

and also for risks that related to the day-to-day operations of the centre. On the day of this inspection, the inspector reviewed a sample of the risk assessments in place and also spoke to staff regarding key risks.

Risk registers were maintained by the person in charge as part of their oversight responsibilities. In reviewing the risk registers, the inspector observed the provider had identified risks in areas such as:

- fire safety
- manual handling
- staffing
- choking
- mobility
- infection prevention and control
- accidental injury
- bruising

Risk assessments reviewed by the inspector were reviewed in line with the provider's policy or the specific time lines identified in risk assessments. For example, centre specific risk assessments such as accidental injury and staffing were reviewed in May 2026. Individual resident risk assessments for bruising and choking were reviewed in July 2026.

The inspector observed that the provider had implemented effective control measures for each of the risk assessments reviewed. For example, the inspector reviewed a risk assessment in place for a resident choking. The inspector observed control measures included staff training, access to a speech and language care plan and guidance on what to do if a resident chokes. The inspector observed evidence that all of the control measures identified were in place.

The inspector also reviewed a risk assessment regarding a residents mobility. Control measures identified in the risk assessment included access to mobility aids, staff training, MDT referrals and, the required staffing levels needed to support the resident. Again, the inspector observed evidence that each of the control measures had been implemented.

The inspector spoke to a staff member regarding key risks in the centre. The staff member spoke confidently and competently regarding risk assessments in the centre. The staff member was aware of reporting structures in the centre in the event control measures were not effective and had a strong knowledge of key care plans that supported risk assessments.

In reviewing important governance and staff meetings, the inspector observed that risk management was a standing item on all meetings.

Overall, the inspection showed that the provider had adequate systems in place regarding risk management. Control measures were observed to in place for all risk assessments reviewed. Risk assessments were found to be reviewed in line with

agreed time lines and staff in the centre had knowledge of risk assessments and corresponding care plans.

Judgment: Compliant

Regulation 28: Fire precautions

While the registered provider had adequate fire fighting systems in place that included fire detection and alarm systems, fire extinguishers, emergency lighting and fire signage, fire doors were observed to be wedged open and gaps were observed in the completion of fire checks by staff.

On the day of this inspection, the inspector reviewed the fire folder and completed a walk around of each of the bungalows that made up the centre. During the walk around the inspector observed a number of fire doors that had been wedged open. This meant that in the event of a fire, these fire doors would not contain any fire. This was pointed out by the inspector to the staff and the wedges were removed. The inspector also observed that the issue of wedging fire doors open was also discussed at a recent team meeting.

In reviewing the centres fire folder the inspector observed the following:

- fire fighting equipment had been serviced in April 2026
- quarterly checks of the fire detection and alarm system had been completed with the last check completed in June 2026
- annual and quarterly checks of the emergency lighting had been completed with the last check completed in July 2026
- annual checks of the fire doors had been completed in August 2026

The inspector reviewed the checks completed by the staff team and observed that in main the checks had been completed but there were gaps in the weekly activation of the fire alarm. For example, the inspector observed that in one bungalow one activation had occurred on 23 July 2026 but the next activation did not take place until 11 August 2026. This meant that the provider could not assure themselves that in the event of a fire the alarm would sound as required.

The inspector also reviewed a sample of resident personal emergency evacuation plans (PEEPS). The inspector observed that plans had been reviewed in May 2026 and provided staff with relevant and accurate information to ensure a safe evacuation in the event of an emergency. For example, guidance was in place for a day-time evacuation, night-time evacuation, how to use additional aids such as an evacuation sled, where to get rescue medications if required and, what staffing supports are required.

In reviewing the training folder, the inspector also observed that staff had completed the required fire safety training.

Overall, the inspection showed that the provider had adequate equipment for fire detection and fire fighting in place which was regularly serviced, staff had received appropriate training and guidance was in place regarding the safe evacuation of residents. However, the inspection also highlighted poor practices in terms of wedging fire doors open and checks on the fire activation panel not consistently occurring.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

While the provider had a range of individual care plans in place for each resident, some plans observed were not subject to review in line with the provider's policy. Some plans reviewed also required more detail to ensure staff were aware of what was required to support residents with their assessed needs.

On the day of this inspection, the inspector reviewed a sample of care plans in place for residents in relation to short term illnesses and diagnosed medical conditions. The inspector also reviewed residents intimate care plans. The inspector observed plans in place in areas such as:

- communication
- mental health
- short term nursing care plans for skin conditions
- osteoporosis
- skin integrity
- intimate care

The inspector observed that in the main the care plans provided guidance for staff in supporting the resident to manage the assessed need, however, in some instances care plans, specifically short-term care plans, were insufficiently detailed or had not been updated following reviews by health professionals. For example, one health care plan in relation to a skin condition had not been updated following a review by a relevant doctor. In addition, as these were short term care plans and were in place to address specific issues over a specified time frame it was essential that they were removed from personal plans or termination dates were included on the plan. The inspector found that this was had not occurred for the care plan described above,

The inspector reviewed one resident's care plan regarding their mental health. The plan had input from members of the providers MDT in terms of psychology and psychiatry. The plan outlined the resident's history of mental illness and outlined actions for staff to support the resident. However, the actions identified required greater detail and the plan required a more regular review. For example, one action was to observe the resident's mood and document changes in the resident's mood or appetite. There was no information available to state what the resident's baseline

was in terms of day-to-day positive mood or appetite, therefore it was not clear what staff should be documenting or when this was outside of recognised norms for the resident. In addition, the last two documented reviews of the plan were in November 2022 and May 2025 which is not in line with the provider's own policy on care plan reviews. This meant that the plan did not provide staff with clear guidance and that there was insufficient auditing of this resident's care plan to ensure its effectiveness.

In summary, the provider had ensured that there were a range of individualised plans in place to support residents assessed needs that had input from health and social care professionals. However, some of the plans reviewed required greater detail in terms of the actions required of staff and some plans were required to be reviewed in line with the provider's own policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had ensured that residents in the centre were involved in key decisions regarding their home and were provided with information regarding accessing advocacy and rights based services.

The provider had ensured that weekly resident meetings were occurring that supported residents to be involved in decision making. The inspector reviewed a sample of the resident meetings and observed agenda items such as safeguarding, advocacy, rights, staffing, restrictive practices used in the centre and meal planning. The inspector observed that meals were now cooked in each of the residents homes and that the residents built the menu for the week ahead.

The inspector observed that residents were informed of the restrictive practices used in the centre and also what the rationale for the restrictive practices are.

The inspector had the opportunity to speak with a resident regarding their rights. The resident told the inspector they felt their rights were supported and gave the example of being able to use their bedroom when they wished without staff telling them they could not go to their room. The resident also told the inspector that they can have family visit them as they wish.

The inspector observed that through the centre contact details of advocacy services were prominent should residents wish to use them. In addition, the contact details of complaints officers and designated officers was also available in an accessible format.

The inspector also observed during a review of the centres training matrix that all staff had completed training in human rights. Staff who spoke with the inspector on

the day of this inspection spoke positively regarding ensuring residents have choice and their voice is heard. In summary, the provider had ensured residents had an appropriate forum in resident meetings to express their choices for their home. The provider had also ensured that residents were kept informed of the contact details of both internal and external agencies should they have any issues with rights access or complaints.
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	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for SVC - AG OSV-0004021

Inspection ID: MON-0045359

Date of inspection: 14/08/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Ongoing recruitment strategies for the centre are being undertaken to fill vacant care staff posts. Rolling care staff advert open on Rezoomo. 1 care staff has been appointed to date to fill 1 care staff vacancy Long term sick leave of 1 nursing staff is being filled through use of consistent relief nursing staff. Regular agency/relief staff allocated to work in Designated Centre where possible. SVC-AG is being piloted in the use of Allocate, a software system use to manage the booking of relief/ agency staff. Aim is to use contracted relief staff rather than rely on agency staff PIC to ensure that both relief/agency staff are identifiable on roster. This will be visible by introducing a separate line for both relief and agency staff on roster. A shared file is available to PIC/Designate to identify what agency staff are affiliated with.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Sluice room to be redesigned as a storage room.. Updated floor plans to be submitted to regulator. Current storage risk assessment to be updated to reflect finding of inspection and identify additional control measures required. Painting schedule in place for St. Vincents Centre, same coordinated by maintenance manager. Archiving of files to be undertaken in the centre	

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Weekly fire alarm activation will be planned and scheduled in the unit diary. Malpractices in relation to wedging fire doors to cease. Communication sent to all staff via Health and Safety Officer on 14th August, 2026. Same to be discussed at October's team meeting. Fire Safety remains a standing agenda item for team meetings.	
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: Personal plan audit schedule to be implemented for 2026/2027. Each personal plan will be reviewed at a minimum annually or sooner if required. Short-term care plans. Once implemented require daily review and update. Regular input of short-term care plans to be overseen by PIC. Same to be discussed at October's staff meeting. All health action plans to clearly identify the assessed need through the use of SMART goal setting. Personal plan assessments will identify each individuals baseline behaviours and patterns including their likes/dislikes/will and preferences.	

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 15(1)	The registered provider shall ensure that the number, qualifications and 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.	Substantially Compliant	Yellow	31/01/2027
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/10/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	28/02/2027

	kept in a good state of repair externally and internally.			
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Substantially Compliant	Yellow	31/10/2026
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/10/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/12/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Substantially Compliant	Yellow	31/12/2026

	needs or circumstances, which review shall take into account changes in circumstances and new developments.			