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 T
Name of provider:	Avista CLG
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	01 April 2026
Centre ID:	OSV-0005739
Fieldwork ID:	MON-0050165

About the designated centre

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

St. Anne's Residential Services - Group T is a single storey bungalow located on its own spacious site in a rural but populated area. The centre is located near a town in Co.Offaly and provides a community residential service for a maximum of four adults with an intellectual disability. While registered to accommodate four residents, three residents currently reside in the centre. The centre is staffed at all times when residents are present and the staff team is comprised of day and residential staff. Management and oversight of the service is delegated to the person in charge who is a clinical nurse manager 2 with support from a home manager. The centre does not provide for emergency admissions.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 1 April 2026	09:15hrs to 18:15hrs	Maureen McMahon	Lead

What residents told us and what inspectors observed

This inspection was carried out to monitor the provider's compliance with the regulations relating to the care and welfare of people who reside in designated centres for adults with disabilities. This inspection found that the provider was not compliant with all of the regulations reviewed. under the capability and capacity domain. For example, an 'urgent action' was issued during this inspection in relation to the deficits identified in the providers staffing arrangements. In the days following this inspection the provider submitted a satisfactory compliance plan outlining how it planned to to address concerns raised on this inspection.

At the time of inspection, three residents were living in the centre. While residents were supported to make choices in their daily life's and to achieve best possible health outcomes, significant improvement was were required to ensure residents received a safe quality service. This included ensuring adequate staffing levels to meet assessed needs, appropriate staff training, compatibility of residents, and effective governance arrangements in line with the complexity of residents' needs. Improvements were also required in aspects of the premises and also fire safety systems.

The house manager facilitated this inspection as the person in charge was on planned leave. The inspection commenced shortly after 9:00am. The house manager, who had been scheduled to begin work at 3:00pm, arrived earlier in response to the unannounced inspection. The inspector met with staff members on duty and engaged with the residents, observing their daily routines and interactions.

The lead staff on duty on the morning of inspection facilitated the inspector to view the centre, meet residents and to view a range of documentation available. The inspector found that staffing on the day of inspection did not align with the planned roster. For example, a staff member due to finish at 11:00am remained on duty for a longer period to support a resident with personal care and manual handling needs. This practice was inconsistent, with some staff indicating that they were comfortable working alone, whilst others reported that is was not safe to provide certain supports, such as personal care and manual handling, without additional assistance.

The inspector observed one resident engaging in their preferred morning routine. This included having tea, listening to music, and relaxing in their sitting room. Recent works had been completed in this sitting room, including padded flooring and walls to support safer movement for the resident. Bespoke seating had also been provided in line with multidisciplinary recommendations. Staff spoken with demonstrated a strong understanding of this resident's needs and communication methods. Staff discussed this resident's recent health issues and how this is now more stable. This resident remained at home during the day and typically did not regularly access the community based on their personal preferences, usually leaving the designated centre once per month. The provider had recently acquired a

bespoke wheelchair to support increased community access, and staff reported this was well tolerated by the resident.

The inspector had the opportunity to be present as staff supported another resident returning from their day service. While this resident did not speak directly with the inspector, they interacted comfortably with staff, discussing plans and preferences, including grocery shopping. Staff were observed to be supportive and facilitated this resident's communication and decision-making.

Local management described that residents' return from day services were staggered to support a better transition back to the house by reducing environmental stressors and promoting a calm atmosphere. On the day of inspection the house manager supported a resident to do a preferred activity prior to returning home. However, once all residents' were present, the inspector noted how the environment became noisy, which may impact negatively on some residents' who were sensitive to busy settings. Staff responded by following guidance, including administering prescribed analgesia for one resident and supporting another to access community activities. However, the compatibility of the assessed needs of the residents living in this house and how the provider intended to resolve the absence of compatibility, had not been adequately addressed since the previous inspection of this centre.

Residents had opportunity to access community based activities based on their wishes and preferences. While one resident preferred to remain at home and host family visits and centre-based activities, others regularly accessed community based activities such as cinema trips, walking, meals out, basketball, reflexology, hotel breaks and spa days.

Overall, while residents' were supported in making choices and experienced generally a good quality of life, the provider was not operating in full compliance with the regulations. This impacted on the consistency of the quality and safety of the service. As mentioned in the opening section of this report urgent improvement was required in staffing levels and arrangements , ensuring staff training requirements were met, and governance arrangements to ensure adequate oversight was maintained so that residents' complex needs are safely and consistently met.

The next sections of this report present the inspection findings in relation to the governance and management arrangements in the centre and, how these governance and management affected s the quality and safety of the service and quality of life of residents.

Capacity and capability

Based on the findings of this inspection the governance and management arrangements in place did not ensure the provider demonstrated compliance with the regulations and did not ensure that the service provided to residents was effectively monitored so that it was safe and appropriate to their needs.

The centre did not present as adequately resourced. On the day of inspection, the inspector found that staffing resources were insufficient to meet the assessed needs of residents. For example, where an assessment completed on behalf of the provider had found a resident required 2:1 staffing for many aspects of daily living, this level of support was not consistently available. In addition, this assessment had been completed in May 2025, and discussions with staff and local management indicated that this resident's needs had since changed due to emerging complex health issues. In response to the urgent compliance plan that was issued on this inspection, the provider confirmed it had increased staffing levels and had initiated a full review of the staffing arrangements in the centre . However, overall, the inspection found the provider needed to proactively and consistently review how the centre was resourced in terms of staffing and equipment to meet residents' assessed and changing needs.

For example, the inspector reviewed recommendations for one resident that recommended the use of a tracking hoist in two rooms to reduce manual handling requirements. This equipment was not in place, and there was no clear, time-bound plan to address this recommendation.

Residents were supported to access day services both within and outside the centre. While one resident was supported in a wraparound day service within the centre, staffing arrangements for this support were found to be inconsistent. The inspector was told that staff varied frequently and were often allocated at short notice. Responsibility for staffing day hours was the responsibility of the day service and not the person in charge, this resulted in a lack of clarity and continuity for the resident.

The provider had prepared a training matrix to monitor staff training, and core staff had completed mandatory and role-specific training. However, the provider was also utilising a staffing agency and it was not adequately demonstrated for the inspector whether agency staff had received appropriate training or induction specific to the centre

The provider had governance and management arrangements in place, with the house manager overseeing the day-to-day operations and the person in charge holding overall responsibility. The person in charge however, was also responsible for two additional centres, dividing their time across all three. Given the complex needs of the residents and these inspection findings, the inspector was not assured that these arrangements ensured sufficient management oversight was in place. Previous inspections had identified similar findings. While the house manager supported the person in charge in the day-to-day running of the centre, they were also required to provide direct care and support to residents, they did not have any protected time to effectively carry out the full range of operational and administrative duties delegated to them.

Regulation 15: Staffing

The provider had failed to ensure that there are enough staff to meet the assessed needs of residents. Significant improvement was required to ensure that residents were supported by a consistent staff team.

The inspector reviewed both planned and actual rotas in the centre for February and March 2026. This review demonstrated that, on a frequent basis, staffing levels were inadequate to meet residents' assessed needs. For example, residents who were assessed as requiring two staff members to support manual handling for personal care and community access were often not provided with the level of support. As a result, residents' personal care routines were frequently organised around staff availability rather than assessed needs.

The inspector was also unable to verify that all staff working in the centre on the day of inspection matched the rota. For example, staff observed supporting a resident were not listed on the centre's roster and reported to a day service manager, with no evidence of oversight from the person in charge. From discussions had with staff members and local management, indicated that staff allocations to the centre changed frequently due to staffing shortages in other areas.

During the period reviewed, there was a high reliance on agency staff to cover shifts. For example, over a five-day period, four different agency staff, each new to the centre, were employed to work shifts. This lack of consistency negatively impacted the continuity of care and support provided to residents.

Overall, these findings demonstrated persistent inadequate staffing levels resulting in residents' assessed need not being consistency met. In addition, the high reliance on unfamiliar staff impacted on the continuity, safety and quality of care provided.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider did not demonstrate how it had ensured that all staff who worked in the centre had been suitably trained.

The inspector viewed the training records for the centre and found that core staff had mandatory training in areas such as fire safety, positive behaviour support and adult safeguarding. Staff had also received training appropriate to their roles and responsibilities such as epilepsy and feeding eating and drinking training (FEDs). However, based on these inspection findings the inspector was not assured as to what arrangements were in place for ensuring what training agency staff had completed. For example, records were not available to review for agency staff who

worked in the centre to verify they were appropriately trained in fire safety, positive behaviour support and also epilepsy given the assessed needs of residents living in this centre. This was discussed with local management who were unable to confirm for the inspector that agency staff had received training in these areas.

The provider did have a procedure for staff induction. The inspector reviewed the induction records for new staff in the centre. This included an induction checklist outlining essential information, such as fire safety procedures and shift-related tasks. However, these induction records were not consistently maintained. For example, six different agency staff worked in the centre in March 2026, and records showed that only one of these staff members had received a documented local induction. Discussion with local management and staff indicated that induction arrangements were informal and ad hoc The completion of inductions relied on the availability of senior staff on duty at the time new or agency staff commenced work. This inconsistency did not ensure that staff were adequately and appropriately familiarised with the needs of the residents and the procedures within the centre and was of concern given the inconsistency of the staffing arrangements themselves.

In addition, the inspector was not assured as to the appropriateness of the staff-skill mix to the assessed needs of the residents. While there was access to other nursing resources within the wider organisation the person in charge was the only nurse available to the centre for direct clinical oversight of residents' healthcare needs. The provider had identified the need for a full-time nursing post in May 2025 but this position remained unfilled at the time of inspection. It was unclear when this post would be filled, which posed an ongoing governance and clinical risk.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, the inspection found that signification improvement was required in the systems of management and oversight that were in place in the staffing arrangements, and resource allocation to ensure a safe, effective, and good quality service for residents.

The provider had established an organisation management structure, as outlined in the statement of purpose. However, this structure was not operating effectively in practice and this had not been identified or addressed by the provider. In the absence of the person in charge, the house manager assumed full responsibility for the day-to-day operation of the centre. Despite this arrangement, the house manager did not have protected time for administration duties and was frequently required to work on the floor to meet staffing needs, as well as provide transport for residents'. During the inspection, the inspector noted a heavy reliance was evident on the house manager to maintain front-line staffing levels - and this impacted on their capacity to complete the management and oversight duties delegated to them.

The person in charge as stated earlier was responsible for two other centres. The limited capacity of these governance arrangements in the context of a busy and complex service is a repeat finding from the previous inspection. While the provider had committed in their compliance plan response to ensuring the house manager would have dedicated time for administrative duties, this had not been implemented. Staffing levels and arrangements overall were not aligned with or appropriate to residents' assessed needs. Induction processes were found not to be robust or consistently undertaken.

The inspector read the most recent unannounced provider six monthly audit, this was undertaken in September 2025. This audit had identified areas that were also highlighted on this inspection, such as the requirement for additional staffing and the submission of a business case seeking additional funding. However, no further updates were recorded on the status of these actions. Issues in relation to dampness were also found by the provider but again remained an ongoing issue on this inspection. Therefore, while the provider had established systems of quality assurance, based on these inspection findings these systems were not effectively used to monitor, assure and improve as needed, the appropriateness, quality and safety of the service provided to residents. In addition, the inspector found that the provider had not adequately implemented the actions it said it would in response to the previous inspection findings. For example, in relation to the capacity of the governance arrangements and transition plans for residents.

Judgment: Not compliant

Quality and safety

While efforts were made to provide residents with a good, safe and quality service that was appropriate to their individual and collective needs, there were matters that impacted on the providers ability to achieve this objective, For example, the inconsistent staffing levels and arrangements described in the previous section of this report and the absence of compatibility between residents.

Residents living in this centre had complex needs, including behavioural support and healthcare requirements. Following the previous inspection completed in April 2024, the provider had reviewed the compatibility of this group of residents to live well together. As a result, a property was identified for one resident to transition from the centre. Local management discussed these plans with the inspector. However, it was unclear from records and discussions when this transition would take place, and a detailed time-bound plan outlining the steps involved to support a successful transition for the resident was not available in the centre on the day of inspection.

The house manager who facilitated this inspection was very familiar with all residents' assessed needs and demonstrated this throughout the inspection. They clearly described residents individual needs and the status of each residents’

personal goals. Residents had access to a range of allied health care professionals, including general practitioners (GP), speech and language therapists, physiotherapists, psychiatrists and psychologists. Where residents had complex healthcare needs, up-to-date detailed care plans were in place.

Of concern in relation to the consistency and evidence base of the support provided was the inconsistent staffing levels, staffing arrangements and systems of staff induction found on this inspection. For example, in relation to the support a resident needed for their personal care and manual handling needs as discussed in the opening section of this report.

The centre compromised of a single house in a rural area. Each resident had their own bedroom which was furnished and personalised to their liking. There was a well-kept garden where residents could spent time outdoors. Residents had access to centre transport to attend day services, appointments and preferred activities. However, some areas of the premises required the review of the provider to ensure they were well maintained. The centre had well-equipped kitchen facilities for food preparation, and residents partook in meal planning and grocery shopping.

Each resident had a personal plan developed and personal goals had been agreed at annual planning meetings. However, as discussed above no time-bound transition plan was available for review on the day of inspection to support a planned transition for one resident.

The provider had recently completed works to create a sitting room for one resident to meet their assessed needs in relation to mobility, falls risk and personal preferences. This room was finished to a high standard, with padded flooring and wall areas to support safe movement. This resident also had access to items they preferred such as a music and a story-telling device.

However, while this evidenced the provider had responded to risks such as risks for a fall and injury overall the inspector found the provider had not identified and responded to other core risks identified by this inspection. For example, there was no risk assessment for the staffing deficit and this resulted in the issuing of an urgent action to the provider.

The provider had systems to reduce and manage the risk of fire. These included staff training, personal evacuation plans and servicing of fire safety equipment by external contractors and checks by staff. The centre was fitted with fire doors throughout the building to reduce the spread of fire. However, improvement was required to the procedures for evacuation in the event of fire evacuation as discussed with local management on the day of inspection.

Regulation 17: Premises

The inspector identified several areas of the centre that required the review of the provider in relation to repairs and maintenance and the provision of appropriate equipment to meet residents' assessed needs.

During a walk around of the centre, the inspector observed that the main bathroom was stained about the base of the toilet. This was a repeat finding from the previous inspection in March 2024. This bathroom was also found to have defective surfaces; panels in the shower areas were raised from the wall, creating gaps that posed a potential infection prevention and control (IPC) risk. The inspector observed concerns in relation to water damage from a shower chair that was leaking into the wall, this had resulted in dampness that had spread to the hallway adjacent to the bathroom. The skylight in this bathroom was unclean, with cobwebs and a significant build-up of dust observed.

The inspector reviewed multidisciplinary records in relation to recommendations for equipment to support minimal handling. In line with these records and the inspectors observations, it was evident that one resident did not have access to the equipment recommended in relation to their assessed needs. A tracking hoist had been identified as recommended to support one residents mobility in May 2025. It had not been installed and it was not evident if the provider had assessed the environment for the suitability of this equipment or had considered other alternatives.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' nutritional needs were being supported in the centre and residents had choices at mealtimes. The centre had a well-equipped kitchen where food could be stored and prepared in hygienic conditions.

Residents went shopping with staff as they wished and if wished took part in food preparation. The inspector observed home cooking on the day of inspection with a pleasant smell filling the centre as staff prepared meals from scratch. Some residents were assessed as requiring a modified diet and the inspector observed staff prepare meals in line with this requirement.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had not identified all risks to the quality and safety of the service and therefore did not have actions or time-bound plans in place to mitigate against these risks.

The provider had maintained a risk register which included both local, environmental and individual risks to residents. General and local risks which had been identified included manual handling, behavioural issues and risks to staff in relation to behaviours of concern. This inspection found that control measures in place were mostly reflective of the risks that had been identified.

The provider also had a system for recording and responding to incidents that occurred. The inspector reviewed all incidents that were recorded in the centre from November 2024 to March 2025 and found there was an effective system for reporting, investigating, and learning from these incidents.

However, some control measures listed were not in place on the day of inspection. Risk assessments had been developed in response to identified needs such as in relation to manual handling, these assessments detailed one resident was awaiting equipment and also was a 2:1 staff ratio where possible for some activities of daily living. However, the required staffing levels to mitigate the risk to the resident and to staff were not consistently in place.

The provider had not assessed and therefore did not have controls in place in response to the risk posed to the quality and safety of the service by the overall deficits in its staffing and governance arrangements for the centre. For example, the inconsistency found by this inspection in those staffing arrangements and the failure to ensure that there was capacity in the governance structure to respond to that inconsistency by implementing controls such as ensuring that all staff had completed formal induction.

Judgment: Not compliant

Regulation 28: Fire precautions

There were processes and structures in place to support fire safety. The centre had self-closing fire doors, firefighting equipment, and an alarm system. However, improvements were required to ensure that fire drills were completed under differing conditions, to demonstrate that all residents could be safely evacuated.

On the day of inspection, the inspector observed there were adequate means of escape. There were arrangements in place for the servicing and checking of fire safety equipment and fixtures, both by external contractors and by staff. Records reviewed demonstrated these checks were up to date.

Fire drill records were reviewed for 2025 and up to March 2026. While regular fire drills had been carried out, none demonstrated the evacuation of a resident with assessed mobility needs from their bedroom or bed. Therefore, the provider could

not demonstrate that it had procedures in place to ensure that staff were able to safely support this resident to evacuate in the event of a fire. This was discussed with local management during verbal feedback of these inspection findings.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had appropriate practices in place for the ordering, receipt, prescribing, storage, disposal and administration of medicines.

The inspector observed that medicines including those with additional storage requirements were kept secure on the day of inspection and detailed records of stock were maintained. Staff were observed preparing and administering medicines, staff were found to be knowledgeable on the medicines prescribed and the possible side effects of these medicines. Where an as required medicine was required the inspector observed staff clearly following the providers policies and procedures in relation to this administration.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were personal plans in place for each resident, which were reviewed at least annually. These plans included each residents health information, assessments including any mental health records, and information about any required communication supports.

The inspector reviewed a sample of two personal plans and found that personal centered planning meetings were held regularly at which goals were set or reviewed. Personal goals were set in accordance with the residents preferences and abilities. For example, one resident was progressing job shadowing in a local business and another resident was focusing on accessing the community for activities such as meals out and visiting local amenities.

Personal planning folders also included sections on healthcare and communication, and these were up to date and provided detailed clear guidance to staff.

Judgment: Compliant

Regulation 6: Health care

Residents healthcare needs were well supported. The inspector reviewed the healthcare plans for two residents and found that residents healthcare needs had been assessed and supported. Residents had access to a range of healthcare services, such as physiotherapy, speech and language therapy and psychology. Where a resident had an identified healthcare need, a detailed care plan was available to view. For example, where a resident had identified feeding, eating and drinking (FEDs) needs, a comprehensive plan was available to guide staff and this guidance was up-to-date. The person in charge was a nurse and was responsible for oversight of all clinical matters in the centre. The provider had identified further nursing oversight was required due to the changing complex needs of residents. This oversight was not yet in place and has been addressed in Regulation 15: Staffing.

Judgment: Compliant

Regulation 8: Protection

The provider had a clear safeguarding policy, and all staff were aware of this and knew their responsibilities in relation to safeguarding residents. Staff had received training in safeguarding and could discuss the learning from this training.

The centre had two current safeguarding plans, local management and staff were aware of these plans, their responsibilities and the measures in place to protect all residents.

Judgment: Compliant

Regulation 9: Residents' rights

This inspection found residents were supported to make choices in all areas of their daily lives.

Staff were observed obtaining consent from residents as they provided support throughout the inspection. Staff were very familiar with the various ways in which residents communicate. For example, staff were observed reading the tone of vocalisations to understand if a resident was comfortable and content. Staff spoke about offering different activities such as the use of music and preferred items such as cups of tea. Residents were supported to make decisions and to change their mind also as wished. Staff were observed supporting a resident to go grocery shopping as they wished to eat something different to what was available in the centre on the evening of inspection.

Residents had access to complaints and advocacy processes and this information was freely available in the centre to inform residents. Residents were supported to keep in contact with family and friends and to access the local community.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The provider had not progressed a long-standing plan to transition a resident to a new centre. Following the previous inspection, the provider had committed to support a resident to transition to a new centre due to identified compatibility issues with peers.

Records reviewed indicated that this resident's support needs had stabilised. This progress, along with safeguarding measures, contributed to a more positive living environment. However, local management outlined the ongoing impact on other residents remained, particularly in relation to noise disruption and competing needs. This impact was evident during the inspection, when the centre became noticeably loud due to a resident’s vocalisations as individuals returned from day services. While the provider had engaged with the local county council and the resident's housing application had been successful, no confirmed timeframe for the move was available to the inspector on the day of inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Substantially compliant

Compliance Plan for St. Anne's Residential Services Group T OSV-0005739

Inspection ID: MON-0050165

Date of inspection: 01/04/2026

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

The provider has completed a staffing review on 27.05.26 on the staffing supports and the needs of the residents in this designated centre. This included a review of current staff rostering system in the designated Centre. The Service Manager, with the PPIM and PIC will review the recommendations of the report and implement the recommended staffing identified. Since this inspection, the Provider has received confirmation of funding requested from the HSE for nursing supports to meet the assessed needs of individuals residing in this centre. The Service Manager has commenced the process of recruitment for these supports. With immediate effect, and pending successful onboarding of staff, the Service Manager, PPIM and PIC will ensure that consistent, appropriately inducted staff from the provider's relief staff pool will be in place in this centre from the 25/05/2026. A recent staff vacancy in the designated centre has been replaced by permanent staff.
An Individual Preference and Needs Assessment (IPNA) has been completed for one resident on 19/05/2026 and IPNA meeting for the second resident is scheduled 23/06/2026. These IPNAs will identify the compatibility and suitability of living arrangements for residents in this centre.
The Service Manager with the PIC, PPIM and MDT will continue to review residential vacancies across the service with a view to sourcing alternative living accommodation with higher nursing supports to meet the assessed needs of one resident. Any alternative accommodation identified/recommended for this resident will be brought forward to the Service Admission, Transfer and Discharge Committee by the Service Manager for approval, proposed date the end of Quarter 4 2026.
All day and residential staff are now recorded on the designated Centre roster since the inspection. This roster has the oversight and sign off by the PIC in the designated centre.
The PIC submitted a housing adaptation grant to the local county council for the provision of tracking hoists to meet residents' assessed needs in relation to manual handling. The local county council has verbally notified the service that the installation of the hoist is not approved on 28.05.26. The Provider will now fund the installation of the

hoist. The hoist has been ordered 02/06/2026.
The PPIM and PIC met on the 03.05.26 to review the staffing roster for the designated Centre. The PIC liaises on a weekly basis with the Day Service Manager to discuss day service staffing requirements for those residents who receive individualized day service from their home in line with their will and preference. A verbal and written handover of information on the wellbeing and activities of residents occurs daily between Day service staff and designated Centre staff. Documentation of all care provisions provided by each team is available for individuals receiving support in the designated Centre.
The PIC, PPIM and Service Manager will ensure oversight of this staffing arrangement to ensure continuity, safety and quality care provision.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

The PIC has reviewed staff induction records for new staff in the Centre, to ensure they are consistently maintained, as per organizational policy DOCS040 Induction & Probation for new staff. The PIC has communicated to all staff at a meeting that took place on 27.05.26 that an induction checklist must be completed with all new staff working in the designated Centre on commencement of first shift. The induction will be completed by the manager or lead person on shift, to ensure that staff are adequately and appropriately familiarised with the needs of the residents and the procedures within the Centre.
Nursing support for the Residents in the designated Centre is currently provided by the CNM2/PIC. The link PPIM/CNM3 is also a nurse and is available to provide nursing support along with CNS in health promotion. Since this inspection the Provider has received confirmation of funding requested from the HSE for nursing supports to meet the assessed needs of individuals residing in this centre. The Service Manager has commenced the process of recruitment for these supports.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The provider has established a clear organisational management structure, as per the statement of purpose. The PIC/CNM2 reports to PPIM/CNM3, and the Home Manager reports directly to the CNM2/PIC. The home manager supports the PIC in managing the day-to-day operations of the Centre.

The PIC will outline on the roster the time dedicated in this centre to protected time to provide governance and oversight. The PIC and PPIM have reviewed the roster 03.05.2026 to ensure support to the Home Manager to complete the duties assigned to them.

The provider has completed a staffing review on 27.05.26 around the staffing supports

and the needs of the residents in this designated centre. This included a review of current staff rostering system in the designated Centre. The Service Manager, with the PPIM and PIC, will review the recommendations of the report and implement the recommended staffing identified. Since this inspection the Provider has received confirmation of funding requested from the HSE for nursing supports to meet the assessed needs of individuals residing in this centre. The Service Manager has commenced the process of recruitment for these supports. With immediate effect, and pending successful onboarding of staff, the Service Manager, PPIM and PIC will ensure that consistent, inducted staff from the providers relief staff pool will be in place in this centre from the 25/05/2026. A recent staff vacancy in the designated centre has been replaced by a permanent staff.

An unannounced 6 monthly provider audit has been completed on 30.05.2026 by the PPIM to review the Centre's progress on actions identified in centre audits and HIQA inspections. The PIC has communicated to all staff at a meeting on 27.05.26 that an induction checklist must be completed with all new staff working in the designated Centre on commencement of first shift. The induction will be completed by the manager or lead person on shift, to ensure that staff are adequately and appropriately familiarized with the needs of the residents and the procedures within the Centre. The Service Manager will have completed input to managers in the designate centre with the HR manager on induction process for all staff by 05/06/2026.

The Service Manager is meeting with the Director of Property and Estates on 02/06/2026 to prepare a schedule and timebound plan for completion of all works identified.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The PIC and PPIM have consulted with the Maintenance team in relation to all issues noted in the inspection report relating to the premises. The Service Manager is meeting with the Director of Property and Estates on 02/06/2026 to prepare a schedule and timebound plan for completion of all works identified.

The PIC submitted a housing adaptation grant to the local county council for the provision of tracking hoists to meet residents' assessed needs in relation to manual handling. The local county council has verbally notified the service that the installation of the hoist is not approved on 28.05.26. The Provider will now fund the installation of the hoist. The hoist has been ordered 02/06/2026.

The skylight in the bathroom has been cleaned, cobwebs and dust removed.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The PIC and PPIM reviewed the residents' risk assessments on 15.04.26 and designated centre's risk assessments on 28.05.26. The designated centre's risk log is reviewed quarterly. Risk assessments are discussed at link meetings between the PIC and PPIM. The Quality Risk and Safety Advisor is currently supporting a review of the risk assessments in this centre and is scheduled to complete a Risk Management training session with staff in the centre on 10.06.2026.
The PIC has developed a staffing risk assessment which is regularly reviewed. A review of one resident's manual handling needs was completed on 05.05.26 by MDT members. The provider completed a staffing review on 27.05.26 on the staffing supports and the needs of the residents in this designated centre. This included a review of the current staff rostering system in the designated Centre. The Service Manager, with the PPIM and PIC, will review the recommendations of the report and implement the recommended staffing identified. Since this inspection, the Provider has received confirmation of funding requested from the HSE for nursing supports to meet the assessed needs of one individual residing in this centre. The Service Manager has commenced the process of recruitment for these supports. With immediate effect, and pending successful onboarding of staff, the Service Manager, PPIM and PIC will ensure that consistent, inducted staff from the providers relief staff pool will be in place in this centre from the 25/05/2026. A recent staff vacancy in the designated centre has been replaced by permanent staff.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

An unannounced fire drill has been completed 06/05/2026 where all residents were evacuated in the designated centre including a resident with assessed mobility needs from their bedroom or bed. The evacuation time from this fire drill was 1 minute and 30 seconds, no concerns were noted. The PEEPs for each individual and risk assessments were reviewed and updated as appropriate on 28.05.26.

Regulation 25: Temporary absence, transition and discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:

The compatibility and placement of residents in the designated centre continue to be raised at ADT. Placement review remains a standing item at all ADT meetings. Since the inspection MDT meetings have been completed for all residents in the designated centre on the 14/4/2026 and 21/04/2026. An IPNA has been completed for one resident on 19/05/2026, IPNA for a second resident is scheduled 23/06/2026. The IPNAs will be reviewed through the MDT process and recommendations, and a clear action plan will be developed following the review. The outcomes and recommendations from these reviews will be escalated by the Service Manager through the ADT process. A progress update on all actions and identified/proposed placement options will be reviewed by the Service Manager and PPIM on a quarterly basis.

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.	Not Compliant	Orange	04/08/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/12/2026
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	08/04/2026

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	27/04/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/05/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	13/07/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	08/04/2026
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in	Substantially Compliant	Yellow	04/08/2026

	good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/09/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding	Not Compliant	Orange	12/06/2026

	the standard of care and support.			
Regulation 25(4)(c)	The person in charge shall ensure that the discharge of a resident from the designated centre is in accordance with the resident's needs as assessed in accordance with Regulation 5(1) and the resident's personal plans.	Substantially Compliant	Yellow	30/12/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	10/06/2026
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	30/05/2026