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:	The Anne Sullivan Centre
Name of provider:	The Anne Sullivan Centre CLG
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	24 June 2025
Centre ID:	OSV-0001388
Fieldwork ID:	MON-0038748

About the designated centre

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

The centre was established specifically to meet the needs of people who are deafblind. The centre provides a residential service to 13 male and female residents. The centre comprises of four houses in a residential cul-de-sac of a suburb of Dublin. There are also two apartments located in an adjacent building. The centre is located a short distance from a range of shops, restaurants and public transport options. Each of the residents has their own bedroom which has been personalised to their own tastes and support requirements. A number of the residents have their own kitchen and living room area while other residents share these areas. There was a communal garden area and walkway around the centre and each of the houses has their own garden to the back of the properties.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 24 June 2025	10:15hrs to 19:00hrs	Gearoid Harrahill	Lead
Tuesday 24 June 2025	10:15hrs to 19:00hrs	Karen Leen	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet 12 of the 13 residents who lived in this designated centre, to speak with their direct support teams, and observe their interactions and routines during this inspection. Inspectors also reviewed how residents and their representatives were facilitated to provide commentary and feedback on their experiences living in this centre, and how this information was being used by the registered provider to contribute to continuous development of the service and the residents' support needs.

As this inspection was announced in advance, residents and their representatives were provided the opportunity to complete a written satisfaction questionnaire. Between responses provided on the day or submitted to the Chief Inspector of Social Services before this inspection, 15 responses were received from residents and their representatives. In the main, survey answers were positive on the quality of the activities, outings, food, houses and gardens, and the kindness and knowledge of the staff supporting residents. Representatives commented that their loved ones were supported to stay in contact with them and to meet up on a regular basis. Some respondents commented on changes they would like to their home, which were also captured and addressed in-house by the provider's own ongoing feedback process.

Through the day, residents were supported by their staff members to tell inspectors what they had been up to, and what their plans were for their day or over the coming weeks. Residents were observed to be consistently included in conversations; for example staff ensured to use each person's communication methods to introduce inspectors to them, and confirm that residents agreed with what staff were saying about them. Staff demonstrated fluent use of signing and tactile communication techniques, and were able to facilitate conversation between the inspectors and residents through real-time translation between verbal speech and sign language. Where some residents were uncomfortable with additional people in their home, this was respected and they were provided assurance that they did not need to participate in the inspection if they did not wish to do so, while inspectors spent time with their housemates. Residents were comfortable around staff and there was a casual and relaxed atmosphere in the houses.

Inspectors met with one resident in their home, the resident was helping staff to set up for dinner. Support staff discussed a number of supports that were in place for the resident in their home. Support staff brought one inspector on a walk through the house and discussed a number of items which helped to promote residents' independence. One resident had an air purifier in their bedroom. The air purifier was used to demonstrate to the resident the day of the week; each day had a different scent. This scent would act as a sensory timetable for one resident who would know what activities they would be participating in both in their home and in the local community. Support staff discussed that the resident enjoyed community activities

such as meals out, walks in the park, getting their hair and nails done, and short breaks away.

Inspectors met another resident who was relaxing in their bedroom on return from a morning appointment. Support staff demonstrated to inspectors how the resident was developing a new picture exchange communication system. Support staff discussed that the resident had a number of picture exchanges in place, however, they were in the process of adding new activity choices as part of the resident's life journey process. The inspectors observed the resident to be smiling and laughing at staff as they discussed the updated communication system with the inspector.

As all residents were each supported by allocated staff members, their routines were generally uninterrupted by those of their peers as residents could come and go freely by foot or by vehicle. There were also nearby public transport options available. Allocation of duties in the worked staffing rosters included ensuring staff who could drive the vehicles were on duty to get residents to their appointments, events and social engagements.

Some residents were observed engaged in sensory activities, in their own room or in a purpose-designed sensory play room with lights, speakers and texture boards. To the rear of one of the houses was a modular garden room in which residents could engage in their activities away from the house, and some residents used the communal areas of the main centre building to hang out with staff, make lunch or tea. Residents were observed relaxing with music and TV shows, with some residents having their own living rooms and activity spaces away from the busier shared areas per their preference.

In the main, the houses were designed and arranged in a manner which was suitable for the residents' preferences and assessed needs. Bedroom and living spaces were highly personalised with photos, artwork, models, sensory items, electronics and the residents' choices of paintwork and furnishings. Where residents used objects of reference to make choices and communicate with other people, these were readily available and accessible to them. Garden spaces were furnished with swings and picnic seating for the residents to sit in the nice weather. Where necessary to aid accessibility, guide rails, poles, contrasting colours and Braille signage was used to aid movement around the houses and surrounding spaces. Residents were supported to use stairs safely and independently, with one resident having a stair lift available to support their safe navigation.

The inspectors observed good examples of positive risk-taking, for example, one deafblind resident was using knives to prepare their dinner with minimal assistance from staff. Features observed around the house were in line with the provision of a restraint-free environment. Locked doors or gates, secure storage of household chemicals or sharps, environmental access restrictions and rights-based restrictions were kept to a minimum, with a small number of residents subject to restrictive practices where a clear risk rationale was identified, and retired in a timely fashion where the identified risk had decreased.

Feedback and commentary from the residents was a prominent feature in the centre's annual report. This reflected on experiences and achievements of the residents through 2024, including residents who were enhancing their own skills in literacy and Braille, residents who had participated in a 5km run in their community, two residents being supported in employment opportunities, residents who attended gyms and swimming, and residents who were going on trips around Ireland and abroad for holidays and weekend breaks.

Team meeting discussions and centre audits also collated feedback and requests on what the residents wished to be different in their home, including maintenance of their gardens, requesting staff not run appliances at certain times of the day, where residents wanted more staff to speak to them using Irish Sign Language (ISL), and where residents wanted changes to their living environment. Inspectors observed examples of connections between the complaints process, feedback questionnaires, staff supervision and quality improvement planning for the centre, and examples of requests and feedback from residents which had resulted in timely changes being effected. At the time of this inspection, the provider had identified residents for whom it was their choice or in their interests to move on to new accommodation in line with a provider decongregation plan. The provider had plans to discuss this with the relevant residents and their representatives when the project was further along.

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

Capacity and capability

The purpose of this announced inspection was to monitor and review the arrangements the provider had in place to ensure compliance with the Care and Support Regulations (2013) and to follow up on information which had been submitted to the Chief Inspector of Social Services. In addition, findings from this inspection contribute to the decision-making process for the renewal of the centre's registration. Overall the inspectors found that the designated centre was sufficiently resourced to provide staffing support and managerial oversight in accordance with the statement of purpose and the assessed needs of the residents.

The management structure of the centre was clearly defined with suitable lines of reporting and accountability. The person in charge was deputised by team leaders to provider managerial oversight seven days a week, and front-line staff were supervised and performance-managed in accordance with provider policy. Topics discussed in staff team meetings and governance reviews included matters which had been raised by residents and their representatives. Evidence gathered from reviewing rosters and speaking with core and relief staff indicated the front-line

team was sufficiently resourced to ensure shifts were consistently filled and covered during staff absences.

The centre was subject to six-monthly quality of service inspections which incorporated feedback and experiences raised through surveys, complaints and resident meetings. The annual review of the centre also highlighted challenges, achievements and improvement initiatives of the preceding year. The inspector observed good examples of actions arising from audits, resident feedback and staff discussions being progressed in a timely fashion as part of the continuous development of the service.

Regulation 14: Persons in charge

Inspectors met with the person in charge on this inspection, and reviewed documentary evidence submitted on their experience and qualifications. The person in charge worked full-time supernumerary hours, and was deputised by team leaders to ensure managerial support and effective seven-day oversight. The person in charge was suitably qualified and experienced for their role and demonstrated good knowledge of their role and responsibilities under the regulations.

Judgment: Compliant

Regulation 15: Staffing

Throughout this inspection, the inspectors met and spoke with front-line staff members across all five resident homes, and reviewed records related to staffing needs and resources. The centre was fully staffed at the time of this inspection per the statement of purpose. Worked staffing rosters identified the hours and locations each team member worked on their shift, including relief personnel and staff deployed to cover shifts in other houses. The roster also identified staff with additional duties such as driving residents to their events, hobbies and appointments, or days that staff were scheduled for training sessions.

Staff members demonstrated strong knowledge of residents' support needs, histories, personalities, interests, current life enhancement objectives and communication profiles. Interactions observed with residents were inclusive and supportive, including providing reassurance to residents who were anxious. Person-centred care was observed to be demonstrated by both contracted staff as well as relief personnel who were on duty. Inspectors observed evidence that the provider utilised a large panel of relief staff to cover annual leave and sickness absences, however relief deployment to the houses was observed to be consistent to mitigate the potential impact on staffing continuity.

Judgment: Compliant

Regulation 21: Records

Documentary evidence required for review related to the centre, the staff, the residents and their supports, and operational oversight were clear, detailed and readily available for review on this inspection.

Judgment: Compliant

Regulation 23: Governance and management

The inspectors reviewed the annual report for this centre for the year ending April 2025. This report reflected on the lived experiences of service users and their representatives through a summary of residents' achievements and challenges through the year, positive and negative feedback, complaints, incident trends and commentary attained through surveys. The report commented on changes in the residents' lives, new or returning social, recreational, work, education and holiday opportunities. The inspectors also reviewed the inspection report from the provider's six-monthly quality and safety audit, which identified areas in which the service was in compliance with regulations, standards and polices, and where initiatives for quality improvement were identified. The inspectors observed examples of where resident feedback had contributed to lines of enquiry reviewed in these audits, and where they informed actions set out for continuous quality development in the centre. For example, a resident had commented that the number of night staff trained in Irish Sign Language had decreased over time, and an action was taken to schedule eight additional staff members to complete a training course. The inspectors met with this resident later on the inspection, who commented that this had improved following their feedback.

The inspectors review minutes of regular staff team meetings, and governance meetings between the person in charge and the provider-level management. The minutes of these meetings contained detailed notes on discussions had regarding staffing matters, incidents and investigations, changes in residents' supports, and progress on team initiatives and projects. The inspectors also reviewed individual supervision and performance management records for a sample of five front-line staff members. The frequency of these meetings was in line with the provider's policy, and records of these meetings covered meaningful topics related to the staff members' duties, concerns, career development goals, and where they required additional support from their line manager.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose outlining the services of the designated centre, which included the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspectors were provided information on complaints received in or regarding this designated centre. The provider retained information on the nature of the complaint, the engagement between the provider and the complainant, and the actions taken on foot of their feedback. The provider recorded how they were assured the complainant was satisfied that their concern had been addressed, and that they had been provided information on appealing the outcome. A summary of complaints received was discussed in the centre annual report to identify any trends or patterns.

Judgment: Compliant

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted their application to renew the registration of the designated centre, along with the required supporting documentation, within the timeframe required under the regulations.

Judgment: Compliant

Quality and safety

The inspectors observed that residents were supported to be safe, active in their home and in their community, and invited to contribute their opinions and feedback to the registered provider. Residents were appropriately supported in their assessed needs related to communication, life goals, positive behaviour support and personal

care. The inspectors observed evidence that residents were being supported in taking positive risks, seeking employment and participating in their community.

Inspectors observed examples, which are discussed elsewhere in this report, of the management and staff team striving to provide residents with new or returned opportunities for social, recreational, educational, recreational, and life skills opportunities. The residents were supported to establish their life goals and enhance the planned and spontaneous activities enjoyed by residents, and optimise meaningful engagement in their local community and personal relationships. Personal, social, health care and life development support plans were done with consultation from the residents and their representatives.

The premises of the centre was overall suitable for the number and needs of residents and promoted principles of restraint-free environment, positive risk taking and accessibility for people with support needs related to vision and mobility. An external fire safety audit had taken place in 2022 which advised additional review was required to identify doors sets which were and were not rated to contain fire and smoke, and upgrade accordingly. There was limited evidence available for review on inspection to confirm the fire protection times provided by doors, door frames, glass panels and attic hatches along evacuation routes. The provider committed to providing this confirmation following this inspection. Other fire safety hazards had been identified on this inspection which had been addressed when brought to the attention of the registered provider.

The inspectors reviewed a sample of assessments of needs and associated support plans and staff guidance regarding needs such as positive behaviour support, communication, mental health care, and general wellbeing, and found these to be cohesive and person-centred, based on evidence and kept under routine and as-required review. Support plans were subject to multi-disciplinary review and were also informed by residents' contributions, incident analysis and risk assessments.

Regulation 10: Communication

Staff were trained in methods of signing and manual communication used by residents, including Irish Sign Language and Lámh. Residents were also supported and facilitated to communicate with others through Braille, touch communication and objects of reference. Inspectors observed examples of conversations between staff and residents, and staff could also effectively facilitate communication between the inspectors and residents using their preferred method. Inspectors also observed examples of how support planning and staff guidance in communication linked to other support structures such as positive behaviour support and personal development objectives.

Residents had access to speech and language therapy reviews which were incorporated into residents' communication support plans. Furthermore, inspectors found that support staff had identified residents' changing needs and incorporated enhanced communication support plans to support residents in the event of further

vision loss. Residents were being supported to develop hand over hand signing in order to reduce possible barriers to future communication.

Judgment: Compliant

Regulation 13: General welfare and development

Inspectors found that the person in charge and support staff promoted residents' independence and choice, and residents were being assisted by staff to actively engage in their local community. Inspectors found that residents were participating in a number of chosen activities such as visits to local museums, art classes which for some residents was an additional form of portraying their communication needs, fine dining, sun holidays, and visits to flight simulators.

Residents were being supported to find opportunities for paid employment, with the provider facilitating opportunities such as the provider employing one resident in supporting front-line staff through further education in Irish Sign Language (ISL) training.

The person in charge and support staff had completed a focus group study identified as a life journey for residents in the centre which focused on residents' experiences, opinions, behaviour and social responses to activities and community choices. Residents in the designated centre had a number of communication systems including ISL, hand-over-hand sign language, vocalisation, picture exchange, sensory communication, and communication tools such as electronic tablets and phones. The purpose of this review was to identify existing activities that residents enjoyed and to enhance new experiences for each resident. The review of information also involved identifying spontaneous activities that residents were participating in to further enhance residents' general welfare and development. Support staff had included the residents and their families in the life journey process.

Judgment: Compliant

Regulation 17: Premises

Overall the premises was designated and laid out to be suitable for the number and assessed needs of the residents. Residents with support requirements associated with being deafblind or mobility difficulties were supported to safely and effectively navigate the centre houses and grounds using bright contrasting colours on steps and thresholds, Braille signage, a stair lift, guiding poles and rails, ramps, and protective padding where necessary to reduce risk of injury. Inspectors observed evidence that residents were supported to make their home as comfortable,

personalised and homely as they wished. Inspectors observed evidence that where residents wanted to make changes or upgrades to their premises, furniture, bathroom spaces or storage solutions, this was discussed in meetings and addressed in a timely manner.

In the main, the premises was clean, comfortable and in a good state of repair. Some areas of wear and tear required attention to maintain the homeliness of the living environment and to address potential risks to fire safety or infection control. This included ceilings, doors, door frames and flooring which were observed to have damaged or peeling surfaces, and holes remaining from removed pipes. In some bathroom areas, painting, resealing or grouting was required to tiles, radiator and support rails which were cracked or rusted, and resident personal care items which required revised storage to reduce risk of contamination.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had suitable systems in place for the assessment, management and ongoing review of risk including a system for responding to emergencies.

There was a risk register in place which was regularly reviewed. Residents had individual risk assessments in place which were subject to regular reviews by the person in charge, the inspectors found that risk assessments in place had appropriate control measures, that were specific to residents' individual health, safety and personal supports. Risk assessments in place included use of restrictive practices, positive behaviour support, community support, fire safety and safe storage and administration of oxygen.

Adverse incidents were found to be documented and reported in a timely manner. These were trended on a monthly basis by management to ensure that any trends of concern were identified and actioned. The inspectors found that accidents and incidents were discussed at staff meetings and plans were put in place to reduce potential risk of possible recurrence and to support residents to continue to develop relationships in the community in a safe manner.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety equipment such as alarm systems, fire extinguishers and emergency lighting were all in good working order and serviced regularly. The provider

conducted practice evacuation drills to be assured that residents and staff could get to a place of safety in an efficient manner.

Following the findings of the previous inspection, the provider had removed all hooks, props and wedges which prevented doors along evacuation routes from closing in the event of a fire, and replaced these with devices which could hold the doors open but release if the fire alarm is triggered. Inspectors tested a sample of these fire doors including in kitchen and laundry room doors, and observed that while the mechanisms released the doors, they did not all fully close on release. This had not been identified for attention on routine checks, as the daily checks by staff observed that exit routes were clear, but did not including testing the door release mechanisms.

The provider had commissioned an external fire risk assessment in 2022 which had identified that there was a mix of door sets throughout the centre, with some rated for fire containment and others which appeared not to be, which required further review. Confirmation was required on how the provider was assured that doors and frames were fire rated to contain flame and smoke, as well as other elements along fire evacuation routes such as attic hatches or glass panels on stairways. Inspectors also observed some ceiling holes from where pipes had been removed which required sealing for containment. The provider advised the inspectors that further review had been carried out to provide assurances that evacuation routes were protected, and that this information would be submitted to the Chief Inspector following this inspection.

Inspectors also observed a full oxygen tank stored in an unsafe manner among electrical and flammable items. Inspectors also observed a living space in which one resident's furniture had been rearranged a year prior in such a manner that resulted in a bed and a wardrobe blocking a fire door from the bedroom to the evacuation route. The furniture arrangement created an inner room which required passage through another room to escape, which had the potential of trapping a resident. Inspectors brought these issues to the attention of the provider, and both issues were rectified before the end of the inspection.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had appropriate practices in place in relation to the handling of medicines, including controlled drugs. The systems in place upheld staff practices in relation to the safe administration of medication in accordance with legislation and guidelines.

Staff were appropriately trained and the provider and person in charge had sufficient audits in place to ensure that safe medication management practices were subject to regular review and monitoring.

The inspectors spoke to three staff in relation to medication management and procedures. Staff were found to be knowledgeable on the reasons medicines were prescribed, aware of residents' known allergies, and the signs and symptoms of known drug allergies. Staff were also aware of the supports required in relation to residents' medication and regular reviews. Staff discussed the systems in place to support residents who regularly went home to visit family and the process of medication reconciliation when going for overnight visits and returning to their home.

The provider had appropriate lockable storage in place for medicinal products and a review of medication administration records indicated that medicines were administered as prescribed. Residents had also been assessed to determine their capacity to manage their own medicines

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed five residents' files and found a comprehensive assessment of need had been completed for each resident which was subject to annual review. Inspectors found that care plans were developed based on the comprehensive assessment of needs and were resident focused and responsive to each individual's specific needs. Furthermore, inspectors found that residents' needs were assessed on an ongoing basis and that supports were in place to ensure that changing or developing needs were adequately met.

Personal care plans were in place and were reviewed regularly with the resident, their representatives and support staff. Inspectors found that key worker meetings were occurring monthly for residents. Support plans in place included communication needs, sensory supports to enhance communication, mental health and wellbeing, medical support areas such as wound management, eye care and epilepsy.

The provider had ensured that the centre was adequately equipped to meet the assessed needs of each resident. In addition, the inspectors found that the provider had made appropriate referral to external support such as community nursing team to further enhance specific areas of residents' support.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors found that where required, residents had a positive behaviour support plan in place. The inspectors reviewed four positive behaviour support plans and found that they were individual to the needs of each resident. The inspectors found that positive behaviour support plans guided staff practice and were linked to integral support plans such as communication needs, sensory supports, wellbeing and mental health supports and family relationships.

The inspectors found that restrictive practices in place within the centre were subject to regular review by the person in charge and support team. In addition, the provider had both a rights restriction committee and a human rights committee, which met monthly to review and discuss these practices. The inspectors found that the rights restriction committee was composed of both internal and external stakeholders, further enhancing its oversight and ensuring a more robust and balanced review of restrictive practices within the centre.

Inspectors found that staff had received training in positive behaviour support to further enhance their practices. Additionally, the inspectors found that staff were in receipt of support and debrief following the implementation of strategies for residents. Support plans were also subject to review by the behavioural support team, support team and members of the multidisciplinary team annually or sooner should there be a requirement.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors observed evidence which indicated that residents were central in choices relating to their routines and activities, and actively consulted in decisions made in their lives. Resident consultation and feedback was sought by the provider and featured in the findings of audits, discussions at staff meetings, and actions in quality improvement plans.

Residents were supported to make choices in how they arranged and decorated their living spaces, and where they wanted changes in their staff support, routines and community participation. Residents were supported to engage in positive risk taking and were not subject to restrictive practices where there was no risk rationale identified for that person. Residents were supported to hold onto their money in the community, travel to meet friends and family and go on holidays, and actively contribute to household chores with appropriate levels of support to encourage their autonomy.

Through observing interactions and speaking with staff members, inspectors observed examples of how staff supported and interacted with residents with respect and dignity. Staff ensured that residents were included in discussions about them and the provider had responded promptly where feedback from residents

indicated this needed to improve. Some residents were provided private living room space based on their support needs or their preferences.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Anne Sullivan Centre OSV-0001388

Inspection ID: MON-0038748

Date of inspection: 24/06/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Maintenance issues in the service are managed through our dedicated caretaker. There is a reporting structure (online maintenance list) where staff can report on any maintenance related issues. Any changes or adjustments to any location is made with the residents needs and preferences at the centre and multidisciplinary team input in sought where required.

All areas highlighted in relation to the premises in this inspection have been added to the maintenance plan. The organization has a maintenance reporting form whereby staff can report on any maintenance issues which are then addressed by our maintenance staff member. Furthermore, the organization has an overall plan for works due to be completed on the premises, for example, painting, floor replacement, bathroom refurbishments. Maintenance is a standing item on our weekly management meeting agenda. The organization also asks residents and staff to provide feedback on the environment and any actions arising from these are managed expediently.

An in-depth audit of each area of the service has been conducted, and any additional refurbishments/wear and tear identified has been added to the maintenance plan for completion over a phased period.

Going forward, regular walkabouts of the service by the management team will take place to ensure that all maintenance-related issues have been identified and escalated appropriately.

A review of storage of personal care items for all residents has taken place, and appropriate alternative storage arrangements have been put in place to address any contamination risks.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The organization's firefighting equipment, alarms, and emergency lighting are maintained on at least a quarterly basis - our alarms are monitored by an external company. Staff and residents complete fire drills throughout the year. Training on fire safety is completed with all staff on induction and is refreshed every 2 years. Staff also complete fire warden training.

A comprehensive audit of fire doors including retainers, door frames, glass panels and attic hatches took place on 8th July post the HIQA inspection in conjunction with an external health and safety officer. An action plan was developed to address issues raised by the inspectors– most actions have been completed to date whilst some actions are in progress (New fire proof attic hatches and fire resistant glass has been ordered and due to be installed).

A further fire safety review has been completed on July 17th by a chartered engineer– our range of fire doors and frames have been examined as part of this and designated fire doors have been confirmed as being in compliance with regulations with either 30-minute or 60-minute fire protection (see report).

All ceiling holes have been sealed as of 21st July.

Regarding the storage of Oxygen. The risk assessment for this has been updated. The tank is now stored on its own in an empty shed and mounted to the wall of the shed. A list of regular checks on the oxygen in the organization has also been put in place to ensure safe management and storage of oxygen in the service going forward.

To improve monitoring of fire safety systems in the organization, enhanced checklists are now in place. These monitor a range of issues such as emergency lighting, alarm sounders, firefighting equipment, means of escape, door closing devices and monitoring whether doors close fully without manual assistance. Regular reminders on fire safety via the organization's weekly newsletter are also planned to raise further awareness of fire safety within the organization.

Fire safety has been added as a standing item on our management meeting agenda.

Fire safety champions, with a focus on promoting and highlighting fire safety within the organization, are being identified and will undergo training in this regard.

The organization’s internal fire safety training is also under review, to ensure that all learnings from the recent inspection, internal and external audits, are integrated into the training and explained clearly to all staff.

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 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	30/11/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2025