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. Vincent's Residential Services Group A
Name of provider:	Avista CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	07 October 2025
Centre ID:	OSV-0001431
Fieldwork ID:	MON-0047498

About the designated centre

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

St. Vincent's Residential Services Group A consists of three bungalows that are located on a campus. The centre provides full-time residential support for a maximum of 15 residents of both genders, over the age of 18 with intellectual disabilities. Residents can attend day services which are located on the same campus and also run by the provider. Support to residents is provided by the person in charge, nursing staff, care staff and household staff. All residents have their own individual bedrooms and other facilities in the centre include bathrooms, living areas, dining rooms, kitchens, laundries and staff rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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 7 October 2025	09:50hrs to 17:45hrs	Kerrie O'Halloran	Lead
Tuesday 7 October 2025	09:50hrs to 17:45hrs	Elaine McKeown	Support

What residents told us and what inspectors observed

This inspection was an unannounced focused regulatory inspection to review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and the National Standards for Adult Safeguarding (2019). Safeguarding of residents is an important responsibility of a designated centre and fundamental to the provision of high quality care and support. The inspection was completed by two inspectors of social services over the course of one day. The inspection had some positive findings, while some areas were identified for improvement which will be discussed in during the report.

St. Vincent's residential service Group A provides full time residential care for adult residents with an intellectual disability. The centre comprises of three houses beside each other on a campus based setting. On the day of the inspection fourteen residents were living in the designated centre, between the three houses. The residents had access to transport which included two wheelchair accessible buses and an additional vehicle could be accessed when required. This supported residents in the designated centre to access their local community and attend appointments.

Over the course of the inspection, the inspectors had the opportunity to meet thirteen of the residents. The inspectors also met twelve staff members, which included household staff, care staff, nursing staff and student nurses. The inspectors also met with the person in charge of the centre, clinical nurse manager and service manager. During the inspection, the inspectors had the opportunity to engage with some of the residents and observe them as they went about their day. Meeting some residents was brief and occurred while some residents were relaxing, watching programmes of interest, preparing or returning from an outing or activity. Two inspectors visited one house, while each inspector visited the other two houses separately.

Residents had varying communication support needs and used speech such as words, vocalisations, gestures, facial expressions and body language to communicate. An inspector observed and spoke to two staff and four residents that were in the living room. The atmosphere was very relaxed and homely, residents appeared to be content and happy in each other's company. Staff were very familiar with residents communication needs. For example, the inspector observed a staff communicating with a resident, the resident appeared to smile, vocalise and have fun with the staff member.

One inspector met with five residents living in one of the houses during the morning. One resident who was visually impaired was introduced to the inspector by a staff member. The resident was listening to a programme on the television in the sitting room. The staff member explained that the resident did not enjoy activities such as massage or other similar sensation activities but was able to indicate to staff by changing their position or with facial expressions if they needed assistance. This

information was later noted by the inspector to be consistent with what was documented in the resident's personal plan regarding their communication.

One resident was completing their breakfast at the time the inspector was conducting a walk round of the house. The inspector greeted the same resident later on while they were sitting in a preferred location in the hallway looking out a window. The inspector was informed the resident enjoyed watching the activity and people passing outside.

One resident returned to the house during the morning after engaging in craft work. This resident requested to speak with the inspector and this was facilitated. The resident spoke of some concerns they had relating to the designated centre. The resident asked that the inspector speak to the person in charge about their concerns. This was done during the inspection and will be referred to in the quality and safety section of this report. The inspector also encouraged the resident to voice their concerns through the complaints pathway or advocacy. The inspector noted the conversation ended following discussions around positive items such as interests the resident had which included craft activities. The resident also spoke about relatives who had musical talents and during the morning the inspector heard the same resident to sing along with staff members and accompanying music.

Two other residents returned later in the morning after attending their activation hub. One resident declined to engage with the inspector but was observed to be supported by staff that were familiar with the resident's preferences. The staff member was observed responding to the resident's vocalisations which indicated they did not want to meet with the inspector at that time. The other resident was visually impaired and required staff to direct them as they walked to different areas within the house. The resident was observed to be informed by staff of the inspector's presence, as well as providing the resident with information as they assisted them to have their meals and drinks.

The staff team explained the importance of ensuring ongoing supports and activation schedules for one of the residents to reduce the risk of the resident engaging in loud vocalisations which could adversely impact on their peers. This included two of the residents who had impaired vision and did not like loud or sudden noises.

There had been some upgrades to equipment within the house since the previous inspection. This included a new bath which was described by staff supporting the assessed needs of one of the residents much better. Another resident had recently commenced using a new shower chair which they informed the inspector was better for them and they liked it. The house had evidence of regular cleaning taking place, was well ventilated and areas including bedrooms were decorated in line with personal preferences. This included photographs of important people in the residents' lives and other personal possessions. The communal areas were decorated with seasonal decorations which the residents appeared to enjoy as some referenced them during conversations with the inspector.

However, four of the residents required multiple aids to assist their mobility and positioning. It was evident storage of such equipment was in a number of locations, this included in a dedicated seated area and in the bathrooms. Staff explained that equipment had to be moved around when supporting residents in such areas. A manual hoist was also being stored in the hallway. The inspector acknowledges that no exits were observed to be obstructed with any equipment.

The inspectors spoke to a number of staff members who were all very familiar with the residents assessed needs. Staff spoke with the inspectors about residents social and health needs and how they support residents. Staff on duty were aware of safeguarding, how to report a safeguarding incident, types of abuse. A staff member spoke with the inspector about regular residents meetings that take place in the centre and how residents are informed of safeguarding through the use of an easy-to-read document in place, along with other items such as activities, centre updates and provider updates. On the day of the inspection, inspectors observed and overheard many kind and caring interactions with staff and residents in the centre.

Overall from what the inspectors observed, residents dictated the pace of the day in the centre. They were supported to have a rest during the day if they wished. Mealtimes and snacks were supported with choice and pictures of different meal and snack options were available to support residents communication needs. Residents were supported with activation staff in their homes and also were supported getting out and about in the community. On the day of the inspection, in one house a resident was supported to visit a train station, staff on duty discussed with the inspector that the resident had a goal to use public transport. A resident in another house was supported by staff to go swimming. While an inspector was visiting this house the staff and resident had just returned from their activity. Staff also informed the inspectors about the residents recent trips such as nights away, attending family functions and concerts.

The inspectors reviewed a sample of residents' support plans which included activity planners. From this it was seen that residents were engaging in their local community on a regular basis. For example, residents were going shopping, using local service such as restaurants, cafes, beauty salons, meeting and spending time with family and friends, bowling, cinema and taking part in activities such as art classes.

Staff were observed to respect residents' privacy in their home. They were observed to knock on residents' bedroom doors before entering. Staff that spoke with the inspectors focused on the residents and their achievements and aspirations. Staff were observed to inform residents with choice regarding their day. For example, one resident liked having a rest during the day and this was supported. Staff were heard asking the resident if they would like to rest now or later.

In summary, it was evident that residents living in this centre were comfortable and content in their home and were taking part in activities they found meaningful in their home and in their local community. Some improvement is required under a

number of regulations which will now be discussed under Capacity and capability, and Quality and safety sections of the report.

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

Capacity and capability

This section of the report describes the governance and management arrangements and how effective these were in ensuring a good quality and safe service.

The provider had governance and management arrangements in place. There were clear lines of responsibility and accountability. A person in charge was in place for the designated centre and was employed on a full time basis. The person in charge was aware of their responsibilities and was very knowledgeable of the residents and their assessed needs. An on-call governance system was in place for the designated centre during times the person in charge was not on duty.

Some improvements were required to ensure the person in charge had access to audits in a timely manner, such as the last six-monthly provider audit that had taken place in July 2025. Along with ensuring regular team meetings were in place for the centre.

The provider had employed staff who had the necessary skills and expertise to support residents, such as nursing staff, care staff and activation staff. The provider supported staff to be aware of their roles and responsibilities in relation to the care and support they provide for residents. For example, staff spoken with were knowledgeable of behaviour support plans and feeding, eating drinking support plans in place for residents.

Overall, this inspection found that arrangements were in place to ensure that residents received care and support that was person-centred. However, review is required under the regulations reviewed under capacity and capability to ensure that systems in place were effective.

Regulation 15: Staffing

The registered provider had ensured that the number, qualifications and skill mix of the staff team was appropriate to the number and assessed needs of the residents. Staffing resources were in line with the statement of purpose. There was a consistent core group of staff, familiar to the residents working in the designated centre. The person in charge worked full time and their remit was over this

designated centre. There was evidence of ongoing review by the provider to ensure adequate staffing resources were available to support the assessed and changing needs of each resident. This included the provision of 1;1 supports and activation staff to residents.

• There was one whole time equivalent staff vacancy at the time of the inspection. The inspectors were informed this vacancy had been recruited for and was planned to be filled the week after this inspection. There were regular relief staff working in the designated centre to fill gaps in the rosters as required.

• A selection of dates on actual and planned rosters since the 21 September 2025 until 18 October 2025, 4 weeks, were reviewed during the inspection. These reflected changes made due to unplanned events/leave and training. The minimum staffing levels and skill mix were found to have been consistently maintained both by day and night in all three houses that were part of this designated centre.

• Details of additional staff resources including activation staff and household staff were also reflected on the rosters that were reviewed.

• The person in charge ensured nursing supports were available to the residents both by day and night to meet the assessed needs of the current residents.

• The provider facilitated the person in charge to be supernumerary to enable them to allocate time to complete administrative duties required of their role. However, the person in charge was also rostered on duty on the front line to support residents and the staff team as required. This included on the day of the inspection where they were they were rostered to provide support to residents from 18:00- 20:00hrs after completing administrative duties during the day of the inspection.

However, while the person in charge had the details of the start and end time of the shifts that were scheduled for the day staff, no details were documented of the hours for the waking night staff on duty in the designated centre or the support staff that worked between the three houses. This was discussed during the feedback meeting at the end of the inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed the staff training matrix for the designated centre. All staff had completed children's first training. After the inspection the person in charge confirmed that all staff had also completed safeguarding training. Some improvement was required to ensure all staff had completed mandatory training . This included:

- Three staff required fire safety training.
- Four staff required managing challenging behaviour training.

- Two staff required manual handling training.

The inspector spoke with staff members who reported that they were supported by the local management and aware of how to report a concern they may have. The inspector reviewed the supervision matrix in place for the centre. This required review to ensure it included when all staff in the centre received supervision, as night staff were not included in this. From the matrix reviewed seventeen staff had received supervision in line with the provider's policy. However from a review of a sample of rosters it was seen that up to twenty-nine staff worked in the designated centre. This required review to ensure all staff working in the designated centre received supervision.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that the provider had a number of systems in place to ensure risks in relation to incidents, accidents and safeguarding in the designated centre.

Some systems required review to ensure documentation was in place and being recorded effectively. There was a clear focus on promoting and ensuring resident's safety and well being. As staff and management in the centre were knowledge and aware of safeguarding, and training was up-to-date in this area.

The centre had an audit schedule in place. A sample of these were reviewed by the inspectors which were completed annually, six monthly or three monthly. These included, mealtime audits, handover audits and health and safety audits. These audits had actions identified with action plans. For these audits the actions identified were seen and documented to be completed.

The inspector reviewed the annual review for the designated centre which was completed in November 2024. The action plan in place was seen to be reviewed and updated with actions identified completed within a time line. Residents and family views had also been sought as part of this audit and were included.

The provider had a system in place to complete six-monthly unannounced audits as required by the regulations. An inspector reviewed the audit completed in place on 8 January 2025, it was indicated on the audit schedule that an audit had taken place again on 10 July 2025. H, however on the day of the inspection this audit was not available for review by the inspector. The inspector did note that it was documented that this audit had been discussed with the person in charge in July 2025. The person in charge did not have access to the audit or action plan for the audit, therefore the action tracker in place had not been updated to reflect any additional actions found on this audit. This required review.

The inspector reviewed the minutes of the team meetings for the designated centre for 2025. It was seen that team meetings were not consistently taking place. For

example, the designated centre completed a team meeting in February 2025, one house had meetings again in May and July, while the other two houses had a team meeting in May 2025. From the records reviewed no other team meetings had taken place. These meetings were seen to discuss a range of items such as, safeguarding, complaints and incidents. Actions were identified in these meeting also which were found not to be completed, such as a review required of a behaviour support plan, this will be reviewed under Regulation 7: Positive behavioural support . This required review to ensure regular team meetings were taking place as per the provider's systems.

Based on a review of the rosters and from speaking with staff it was evident that the person in charge was present in the designated centre on a regular basis. The person in charge had worked in the centre for a number of years and was very knowledgeable of the residents assessed needs. The person in charge worked and was present in all three houses of the designated centre. They had the qualifications, skill mix and experience to for fill the role. Residents were observed to be comfortable in their presence. The person in charge spoke about the importance of ensuring residents were safe, happy and living a good quality life.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality and safety of service for the residents living in the designated centre. This inspection found that systems and arrangements were in place to ensure that residents received care and support that was safe, person-centred and of good quality.

The centre was last inspected in April 2023, where areas for improvement were identified for the designated centre under Quality and Safety regulations reviewed. On this inspection, it was found areas for improvement were also identified and will be discussed under each regulation below.

As mentioned earlier in the report, the centre was seen to be clean, tidy and homely. Residents bedrooms were seen to be decorated with their personal items. Some review was required to ensure the centre had storage facilities for equipment, this will be discussed under Regulation 17: Premises.

One resident spoke about concerns they had to an inspector which included interactions with peers and staff, their living arrangements and personal possessions. The resident communicated their concerns very well and identified staff with whom they would speak to about their concerns. The resident gave the inspector permission to discuss their concerns with the person in charge during the inspection. It was evident from speaking with the person in charge that staff were aware of the resident's voiced concerns and supports had been put in place, including access to advocacy supports and making a complaint on behalf of the

resident. It had also been identified that some of the concerns related to historic situations that no longer existed for the resident at the time of the inspection.

Residents had support and risk assessments in place which had considered their safety and safeguarding. Restrictive practices were in place in the designated centre, these are to be reviewed on an annual basis, on the day of the inspection these were overdue review. This will be discussed under Regulation 7: Positive behaviour support.

Overall, the inspectors found that residents lived a meaningful and good quality life. Residents were supported by staff on day trips and holidays, along with regular community activities and in house activities. Some residents enjoyed attending classes, such as art and crafts.

Regulation 10: Communication

Residents were kept informed of the supports available to them in a manner that was meeting their communication needs and preferences. Staff were observed to be aware of residents specific communication preferences and were responsive to requests made by residents both verbally and non-verbally. Both inspectors observed many examples of this throughout the inspection. This included monitoring a resident's facial expressions and non –verbal cues such as body language when a resident displayed increased moving in their chair, the staff were aware of what this indicated for the resident. An inspector observed staff speaking to one resident and observed the staff waiting for a gesture, non-verbal cue to indicate what the resident would like. Another staff was overheard telling a resident about their plans for the day.

From a review of the residents' personal plans, residents had their communication needs assessed. Residents had communication passports in their care plan which described how staff should present information to them in a way that best suits their communication needs, styles and preferences.

Where an assessed need had been identified, residents had access to speech and language therapy. Recommendations made were available in residents support plans. These recommendations were clear and informative for staff, and supported residents feeding, eating and drinking support plans. Staff spoke to an inspector about these recommendations.

There were visual signs and social stories to support with fire evacuation and communal living. Easy-to-read documents were available to residents and discussed at monthly residents meetings. For example, an easy-to-read document was available regarding the upcoming election.

From the personal plans reviewed, residents had communication dictionaries developed in their personal plan, this clearly identified words the resident may communicate and what these words mean. The staff spoken with informed the

inspector how informative this was and it supported staff in facilitating the resident's communication needs.

The inspectors saw that communication of all forms was respected and responded to. The inspectors saw kind and caring interactions between residents and staff, and staff were able to use their knowledge of residents and their routines to promote responses.

Judgment: Compliant

Regulation 17: Premises

The designated centre had a homely atmosphere throughout. All three houses that comprised of the designated centre was noted to be clean, well ventilated and well furnished. Residents had access to private space, with each resident having their own bedroom, along with adequate communal space. Residents had storage available in their bedrooms for their personal items. Laundry facilities were also available.

Some improvement was required in one of the houses of the designated centre as communal spaces were used to store necessary mobility aids for residents. Staff had to move such equipment in areas such as the bathroom and a communal seating area when these areas were required for use by residents.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had systems and processes in place for risk management at this centre. The centre had a risk register in place. Resident's had individual risk assessments in place, where risks to their well being and safety such as abuse was identified, assessed. Some review was required as not all risks identified in the designated centre had been risk rated or subject to recent review as per the provider's own policy on risk management.

- For example, in March 2025 a risk from hot water for one resident had been identified. There were documented control measures in place but no risk rating and the risk was scheduled to be reviewed in September 2025 and this had not taken place at the time of the inspection.
- A risk identified for a resident relating to the management of an underlying medical condition had a control measure in place which included the daily administration of a named medication. This medication had been documented

in the resident's health care plan as being stopped since the resident's most recent discharge from hospital in August 2025.

- A resident who had an identified risk of choking had documented control measures which were not consistent with the recommendations made by a SLT in August 2025. The required amount of fluid thickener documented differed in the documented risk.
- A risk assessment in place for a resident regarding their wheelchair, which had previously been awaiting a part to fix it was due for review since June 2025. On the day of the inspection the resident's wheelchair was in place and the person in charge informed the inspector that this had been since fixed.
- A half door was in place in the kitchen of one of the houses of the designated centre. This had been identified as a risk for one resident and action had been taken by the person in charge with the door to be replaced with a full door. However no risk assessment was in place identifying this for the resident .

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed a sample of six residents' personal plans. The plans reviewed by the inspectors were found to be individualised, clear and informative, but some further review was required. Staff spoken with were knowledgeable regarding the care and support needs of residents. For example, staff members discussed with the inspectors the residents likes, dislikes and goals residents had achieved and were aspiring to achieve over the next few months.

During the course of the inspection residents were seen to be supported by staff with meaningful activities. The centre had access to activation staff to provide support to residents in accessing the local community and other activities. Residents were supported to engage in sensory activities within the designated centre and in the community in line with expressed wishes. For example, one resident who was visually impaired was able to mobilise with staff support, hand rails were also in place in communal areas for the resident to use and they were supported to enjoy activities such as hand massage within the designated centre.

For the most part in the plans reviewed, residents had been supported with an annual planning meeting which supported the resident in goals they would like to achieve and a review of the year that had passed. Residents had identified goals such as planning to attend concerts, use public transport, day trips to places of interest and plan overnight trips. Goal recording sheets were in place and staff supported residents with their goals and documenting progress on their goals. Some resident's plans had pictures in place of progress they had made with their goals.

Review was required in areas of resident's personal plans. This included:

- One resident's person centred planning meeting was last documented to have taken place in May 2024, an inspector was informed that a meeting had taken place in 2025 however, no documentation was available on the day of the inspection.
- Residents were being supported to maintain their independence where possible such as feeding eating and drinking. However, one resident required staff support with their fluid intake due to an ongoing medical condition. The resident had a strict fluid intake documented which included variations to reflect warm weather. However, on review of three sample dates of this resident's fluid balance record two of the dates did not accurately reflect the actual intake of fluids taken by the resident. This included the day prior to the inspection.
- One resident's fall screening tool required review. It was dated to have been last reviewed in February 2024 and reflected a previous designated centre the resident lived in.
- One resident had two epilepsy management plans in their personal plan, one was dated 2023, while the other had been updated in 2025. This required review.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There were restrictive practices in place for this centre. The provider had ensures these practices were notified to the Office of the Chief Inspector on a quarterly basis. The inspectors reviewed the designated centres restrictive practice register which contained a full record of all restrictive practices in place in the centre. This had last been reviewed in June 2024. As per the provider's policy promoting a restraint free environment, which was last reviewed in May 2025, all restrictive practices should be reviewed annually. The person in charge and service manager informed the inspectors that this review meeting was scheduled to take place in October 2025.

The inspectors reviewed behaviour support plans in place for three residents. Two of these plans had been reviewed in January and April 2025. These behaviour support plans outlined supportive strategies, information about triggers and guidance for staff on managing situations with responsive strategies. It was evident that there was sufficient detail in the positive behaviour support plans and that staff were familiar with these plans to ensure that residents were protected and supported. One of the behaviour support plans had been identified as awaiting an update in the team meeting minutes in February 2025, this plan was documented as being in draft format since March 2025. On the day of the inspection this plan was still in draft format.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had taken measures to safeguard residents from being harmed or suffering abuse. Policies and procedures were in place to ensure residents were safeguarded. All staff had received training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity. Staff spoken to during the course of the inspection were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm.

On the day of the inspection, the inspectors were informed there were no open safeguarding plans in the designated centre. Four safeguarding plans were reviewed. Some review was required to ensure all plans present in the designated centre had documented review dates and were closed. For example:

- A formal plan in place for one resident following an incident that occurred in November 2023 and was closed in February 2024. Two more recent safeguarding plans following an incident in July 2025 had documented evidence of review in August and October 2025 but no details of when the next review was to take place or if the safeguarding plans were closed. Another safeguarding plan dated July 2024 had not documented if the safeguarding plan was closed.

A safeguarding folder was in place in the designated centre. This folder contained information regarding safeguarding, including a managers toolkit about safeguarding. Safeguarding was discussed at regular residents meetings, and was seen to be an agenda item at team meetings also. Easy-to-read documents were in place for residents to access about safeguarding.

The inspectors reviewed intimate care plans that were in place in residents personal plans. These contained clear guidance to staff and the supports required for residents living in the centre.

The provider also had a protocol in place in the designated centre to support a resident and the staff team with allegations. This was clear and informative and supported a resident with needs that may adversely impact others.

Judgment: Substantially compliant

Regulation 9: Residents' rights

In this designated centre, residents were supported by staff to have choice and by provided with information regarding their rights. Residents were engaging in meaningful activities such as train journeys to other towns, boat trips and overnight breaks in hotels. Residents were supported to go the cinema regularly and enjoy their preferred refreshments which could include a meal out. One resident spoke of their preferred routine each time they went to the cinema which included a specific request of a beverage which staff supported.

The centre had access to activation staff which supported residents with their daily activities in the community and in their home. Staff resources providing one to one supports to residents were also in place. Residents were supported with ongoing review and discussions to identify preferred activities and their choices listened too. This included assisting one resident to book tickets for upcoming concerts in the local area, visiting relatives and engaging in community activities regularly. Residents were supported to be involved in monthly residents meetings. There were reviewed for 2025 and seen to take place regularly. These meetings discussed complaints, safeguarding, social roles, environmental updates and advocacy.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. Vincent's Residential Services Group A OSV-0001431

Inspection ID: MON-0047498

Date of inspection: 07/10/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The off duties for the designated centre now include the actual hours for the night staff and the support staff.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff who required fire training and manual handling have now completed same. The staff requiring training in management of challenging behaviour training have being booked for same which will be completed on 19.11.2025. The supervision matrix has been updated to include dates for all staff working within the designated centre.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The six monthly audit is now available for the PIC and all actions have been completed and documented.

Team meetings have occurred for all houses and will be scheduled for every 4-6 weeks going forward.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The PIC and PPIM have reviewed the storage facilities in one of the houses in the designated centre to ensure best practice.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk assessments for the designated centre have been reviewed and updated by PIC and PPIM. The Provider's Quality and Risk Advisor has been requested to review the updated risk assessment to ensure all risks are identified and required control measures in place which will be completed by 28.11.2025.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The fluid intake record for one resident has been updated to ensure that the intake is accurate.

The PCPs for all residents are now in date and available in each resident's Personal Plan.

All documentation in Personal Plans has been reviewed and archived where necessary to ensure the information in Personal Plans is current and accurate.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: All restrictive practices in the designated centre have been reviewed and updated. The Behaviour Support Plan is no longer in draft and copy of same in located in resident's Personal plan.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Date of closure has been logged by the PIC on the safeguarding documentation from previous referrals.

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	12/10/2025
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.	Substantially Compliant	Yellow	19/11/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	12/10/2025
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/10/2025

Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	28/10/2025
Regulation 23(2)(b)	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 maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Substantially Compliant	Yellow	14/10/2025
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and	Not Compliant	Orange	12/10/2025

	assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Not Compliant	Orange	12/10/2025
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	28/11/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently	Substantially Compliant	Yellow	14/11/2025

	than on an annual basis.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	12/10/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	16/10/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	12/10/2025
Regulation 08(3)	The person in charge shall	Substantially Compliant	Yellow	12/10/2025

	initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			