Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	St. Anne's Residential Services Group M
Name of provider:	Avista CLG
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	12 November 2025
Centre ID:	OSV-0005162
Fieldwork ID:	MON-0048869

About the designated centre

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

St. Anne's Residential Services Group M is a designated centre operated by Avista CLG. It provides a community residential service to a maximum of five adults with a disability. The centre is a three story building which consists of a kitchen/dining room, sitting room, five resident bedrooms, staff sleepover room/office and a number of shared bathrooms. There is a well maintained garden to the rear of the centre which contains a Seomra. The centre is located in a rural village in Co. Tipperary and is close to local amenities. The staff team consists of a team leader and care assistants. The staff team are supported by the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 12 November 2025	09:40hrs to 17:30hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted to monitor on-going compliance with the regulations with a specific focus on safeguarding. This inspection was carried out by one inspector over one day.

The inspector had the opportunity to meet with the four residents in the afternoon of the inspection. The four residents were attending day services on the morning of the inspection. The inspector also met with two staff members.

On arrival to the house, the inspector met with a staff member who told the inspector the four residents had left to attend their day services. The person in charge was on annual leave on the day of the unannounced inspection so the inspection was facilitated by the staff team and covering clinical nurse manager. The inspector spent the morning and early afternoon speaking with staff members, walking through the premises and reviewing documentation.

Later in the afternoon, the inspector observed the four residents returning home and they appeared content to be home. The residents were observed settling in for the evening. One resident had a cup of tea while watching TV in the kitchen while a second resident watched TV in the living room. The third resident went straight up to their bedroom and prepared a bath. The fourth resident was observed tidying up the house, taking the bins out and preparing dinner with staff support. One of the residents spoke of their day and three of the residents told the inspector that they liked their home. The inspector was informed of upcoming plans to go to Christmas markets and visits home to family members. Overall, the residents appeared comfortable in their home and in the presence of the staff team.

The inspector carried out a walk through of the house accompanied by a staff member. As noted, the centre is a three story building which consists of a kitchen/dining room, sitting room, five resident bedrooms, a staff sleepover room/office and a number of shared bathrooms. The residents had access to a vehicle to support them with community-based activities.

Overall, the centre was well maintained, decorated in a homely manner with residents' personal possessions throughout the centre. All residents had their own bedrooms which were decorated to reflect the individual tastes of the resident. For example, some residents had posters of bands they liked or photos of people important to them. The previous inspection identified there were areas of the premises which required attention including external paint and soffits and fascia in need of repair. This had been addressed. However, the inspector observed three fire doors being wedged open which required review.

In summary, the residents appeared content and comfortable in their home and the staff team were observed supporting the residents in an appropriate and caring manner. However, some improvement was required in fire safety.

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

Capacity and capability

There was a clearly defined management system in place which ensured a good level of oversight of care delivery in the designated centre. On the day of inspection, there was appropriate staffing arrangements in place to meet the care and support needs of the residents'.

The centre was managed by a full-time, suitably qualified and experienced person in charge. There was evidence of regular quality assurance audits taking place to ensure appropriate oversight and that the service provided was effectively monitored. These audits included the annual review for 2025 and the provider's unannounced six-monthly visits. These quality assurance audits identified areas for improvement and action plans were developed in response.

On the day of inspection, there was sufficient staffing levels in place to meet the residents' needs. There was an small established staff team in place which ensured continuity of care and support to the residents. From a review of training records, it was evident that the staff team in the centre had up-to date training.

Regulation 15: Staffing

The registered provider ensured that the number, qualifications, skill mix and experience of staff was appropriate to the assessed needs of the residents. The person in charge maintained a planned and actual roster. The rosters were developed on a five week rolling basis. From a review of the rosters for October 2025 and November 2025, the inspector found that there was a core staff team in place which ensured continuity of care and support to residents. At the time of the inspection, the designated centre was operating with one vacancy. This was covered by the existing staff team and regular relief staff.

During the day, the four residents were supported by two residential staff members in the morning and afternoon. In the evening the four residents were supported by one staff member and at night, one sleep-over staff was in place. At the weekend, the residents were supported for the most part by two staff during the day and one staff on sleepover. While there were occasions where there was only one staff in

place at the weekend, this was in line with safe staffing levels and, at the time of the inspection, did not have a negative impact on the residents choice and control and daily routines.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. From a review of a sample of training records, it was evident that the staff team in the centre had up-to-date training in areas including safe administration of medication, safeguarding, fire safety, de-escalation and intervention techniques and manual handling. This meant that the staff team had up-to-date knowledge and skills to meet the assessed needs of residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. At the time of the inspection, the person in charge was also responsible for two other designated centres. From a review of the visitors log and speaking with staff the person in charge was regularly in the house and available to the staff team and residents.

There was evidence of quality assurance audits taking place to ensure the service provided was appropriate to residents' needs. The quality assurance audits included the annual review 2025 and six monthly provider visits dated October 2024 and April 2025. The clinical nurse manager noted that they planned to complete a six-monthly inspection in the weeks following the inspection. In addition, there were local audits completed in personal plans and health and safety. The audits identified areas for improvement and action plans were developed in response. For example, the annual review identified the need to a review of the admission process following the recent admission of a resident. This had been completed.

Judgment: Compliant

Quality and safety

Overall, the inspector found that this centre was a comfortable home which provided a good standard of person-centred care and support to the residents. However, some improvement was required in fire safety.

The inspector reviewed the four residents' personal files which contained an up-to-date comprehensive assessment of the residents' personal, social and health needs. The personal support plans reviewed were found to be up to date and to suitably guide the staff team in supporting the residents with their assessed needs. The inspector found that there were appropriate systems in place to support the residents with identified risks in the centre and to safeguard the resident.

There were suitable systems in place for fire safety management. However, on the day of the inspection, the inspector observed three fire doors wedged open which negated the purpose and function of the fire door. This required review.

Regulation 10: Communication

The residents communicated their needs and preferences verbally. Each residents' communication style was outlined in their personal plans which guided the staff team in communicating with the resident. Communication passports were developed and a sample reviewed demonstrated that they were personalised to the individual. The staff team spoken with demonstrated a clear understanding and knowledge of the residents' communication preferences. The residents also had access to magazines, newspapers and Internet as they wished.

Judgment: Compliant

Regulation 17: Premises

The designated centre was designed and laid out to meet the needs of the residents. The designated centre was decorated in a homely manner and generally well maintained. The residents' bedrooms was decorated to reflect their individual tastes. The previous inspection identified a number of areas in need of attention, including; the external paint of the premises, internal paint peeling in some rooms, areas of damp in one bedroom and areas of the soffits and fascia in need of repair. This had been addressed as the soffits and fascia had been repaired and internal and external painting completed. There was no evidence of damp in any bedroom.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that there were systems for the assessment, management and ongoing review of risk. The inspector reviewed the risk register and found that general and individual risk assessments were in place. The inspector reviewed a sample of risk assessments including falls, behaviour and feeding, eating and drinking. The risk assessments were up to date and reflected the control measures in place.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. A personal emergency evacuation plan (PEEP) had been developed for each resident to guide staff in the effective evacuation of the centre, if needed. There was evidence of regular fire evacuation drills taking place in the centre which demonstrated that all persons could evacuate the centre to a safe location in a timely manner.

The previous inspection found that it was not demonstrable on the day of inspection that the containment and evacuation measures in place were adequate in the sitting room. The registered provider engaged the service of a suitably qualified person and this has been addressed through the installation of a fire rated door. However, three fire doors were observed wedged open during the inspection. This practice negated the purpose and function of the fire door and compromised the effectiveness of the fire containment measures in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment of needs in place which identified the residents' health, social and personal needs. The assessment informed the residents' personal plans. The inspector reviewed a sample of residents' personal files and found that they appropriately guided the staff team in supporting the residents with their identified needs, supports and goals. There was evidence that the effectiveness of the personal plans were reviewed annually by the multi disciplinary team and residents circle of support. Each resident had meaningful goals in place including attending events, going to matches and developing skills.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and positive behaviour support guidelines were in place, as required. The behaviour support guidelines outlined proactive and reactive strategies to support the resident. Residents were supported to access psychology and psychiatry as required.

There were systems in place to identify, manage and review the use of restrictive practices. There were two restrictive practices in use in the designated centre including a locked wardrobe and transport seating plan. Records demonstrated that the restrictive practices were appropriately identified, assessed and reviewed to ensure they were the least restrictive practice in place. There was also evidence of a reduction of one restrictive practice.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in place to safeguard residents. The inspector reviewed a sample of incidents and accidents occurring in the designated centre for January 2025 to November 2025 and there was evidence that incidents were appropriately managed and responded to. Safeguarding plans were in place to guide the staff team and manage identified areas of concern. The staff team had up-to-date training in safeguarding vulnerable adults and demonstrated a good knowledge of reporting and responding to concerns. The residents were observed to appear content and comfortable in their home. A number of the residents told the inspector that they were happy in their home.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to have choice and control in their daily lives. The service provided was lead by the residents. The inspector reviewed a sample of minutes of the weekly meetings held with residents to discuss aspects of the service, the upcoming menu and planned activities. In addition, monthly advocacy meetings were also taking place. From review of documentation, the use of professional and respectful language was used throughout residents' assessments and plans.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. Anne's Residential Services Group M OSV-0005162

Inspection ID: MON-0048869

Date of inspection: 12/11/2025

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 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The registered provider has approved of the fitting of electric magnetic fire door holders for 2 doors. The remaining fire door will be kept shut at all times.	

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 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/01/2026