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:	Ashington Group - Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 7
Type of inspection:	Unannounced
Date of inspection:	30 September 2025
Centre ID:	OSV-0003979
Fieldwork ID:	MON-0048289

About the designated centre

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

The following information has been taken directly from the registered provider and describes the service that they provide.
The Ashington Group consists of two community-based homes and is part of a community residential service operated by Avista CLG (formerly known as Daughters of Charity Disability Support Services CLG) that provides a high level of support and care to up to six people with intellectual disabilities. The community houses are semi-detached with a shared conservatory, situated in a quiet residential area. All residents living in Ashington Group have single occupancy bedrooms. The houses have communal bathrooms, kitchen, dining and sitting room areas and rear gardens. The houses are long stay residential homes which are open 24 hours a day, seven days a week. They are staffed by a person in charge, staff nurses, social care workers and health care assistants. Staff support residents to attend day services or individual activities daily.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 30 September 2025	10:40hrs to 17:30hrs	Brendan Kelly	Lead
Tuesday 30 September 2025	10:40hrs to 17:30hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This inspection was unannounced and carried out with a specific focus on safeguarding to ensure that residents felt safe in the centre they were living in and were supported to make decisions about their care and support. It took place on 30 September 2025 and was completed by two inspectors on one day. The inspection examined governance structures, staffing, training and development of the staff team, resident experiences, safeguarding, protection, care plans and premises.

On the day of inspection four residents were present in the morning with one resident having already left for the day when inspectors arrived. Inspectors had the opportunity to briefly speak to three residents who were in the conservatory getting ready, to leave for their day. The three residents appeared happy and were looking forward to the days activities. One resident briefly chatted about being a human rights champion and said that they were very happy in their home. A second resident talked to the inspectors about the plans for the day and also stated that they were happy in their home. One resident remained behind with staff as they were being collected in the afternoon. With the help of a staff member the resident informed the inspectors of their plans for the day. The resident then showed the inspectors around their home.

During the course of the inspection the fifth resident who had already left when the inspectors arrived in the morning, returned home from their day. Inspectors observed this resident relaxing on the couch watching some television and interacting with staff. Residents were observed to be at ease in their home and with each other. Inspectors observed some residents greeting one another on their return from an activity and one resident was observed saying goodbye to the staff in the house as they left to go on a planned outing to bowling.

While there were maintenance issues identified on the day of inspection, such as repair of a living room ceiling following a leak, a wardrobe door not on its hinges and general wear and tear, the designated centre was in the main warm, homely and laid out to suit the needs of the residents. This centre comprises two interconnected semi-detached houses. The first house in the centre had a small but comfortable sitting room that was well decorated and had photos of the residents engaged in various activities, the kitchen was clean and a variety of fruit, snacks and other food items were available for residents. A shared conservatory was available for the residents of both houses. Upstairs there was a small main bathroom that had shower access for residents. All resident bedrooms were decorated to their own individual preferences and contained photos of family and residents engaged in various activities.

The second house in the designated centre was next door to this house and of a similar layout. A small but comfortable sitting room contained arts and crafts that residents used on a daily basis. The staff member who remained with the resident in this house was also preparing a home cooked meal for residents in the kitchen. Each

bedroom in the house was decorated to the residents choosing with evidence of hobbies and photos of families also present. Inspectors observed two adjoining doors between the houses, one in the kitchen and one in an upstairs bedroom that opened to another bedroom in the house next door. Inspectors observed that in both cases the doors were not used by staff throughout the day of inspection although one resident did open the door between the two kitchens to say goodbye to staff as they left for their day.

All residents were observed by inspectors to be comfortable in their home and staff were observed to be kind, caring and professional in their interactions with the residents. Added to this, residents appeared to be comfortable and relaxed in the company and presence of staff. Notwithstanding these observations, issues were identified during the course of the inspection in relation to governance and management, training, protection and premises.

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

The inspectors found that there was a clearly defined management structure in the centre with changes to the local management team in the preceding months. The new person in charge was endeavouring to apply the provider's systems to oversee safeguarding procedures in terms of identifying, reporting and implementing measures to mitigate safeguarding concerns. Inspectors were not assured that the registered provider had as yet consistently applied systems to accurately identify, report and manage safeguarding concerns.

There was a committed and consistent staff team in place to ensure that residents were safe, the number of staff available to support residents was reduced at times due to staff vacancies and periods of leave. This did not appear to have an impact of the quality of resident care and support.

Regulation 15: Staffing

Overall, the registered provider was striving to ensure staff complement and skill-mix was appropriate to the number and assessed needs of the residents living in the centre at the time of the inspection. The provider and person in charge endeavoured to fill vacant shifts on the roster to ensure consistency of support and that the full staff complement was available to residents at all times.

Inspectors reviewed the September 2025 planned and actual rosters, which were well maintained and outlined the designated shift lead for each day. The centre currently has one whole time equivalent vacancy which was covered where possible using familiar relief staff and regular agency staff. In total 15 shifts in the month of September were covered by agency staff. Inspectors reviewed the centre induction folder and confirmed that agency staff who worked in the centre in September had received an induction that outlined the individual needs of the residents, diagnosed medical conditions and emergency procedures.

Throughout the day of inspection inspectors observed staff to interact in a professional, caring and warm manner with residents. In addition, residents appeared comfortable and happy in the presence of staff. Inspectors also met and spoke with two staff working on the day of inspection. Both staff were knowledgeable of the residents, areas of risk in the centre and were fully informed of safeguarding procedures.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors reviewed the centre's training matrix, supervision schedule and supervision records held in the centre. On review of the training matrix, inspectors found the dates for staff completing training had not been recorded accurately. Dates for staff completing training were missing for 13 areas of training including training that was identified as mandatory such as Children's First, Safeguarding Induction Training, Fire Safety Training and Introduction to positive behaviour support. In addition other areas of training were also found to have gaps in recording such as a Human Rights Approach, Seizure Management and various infection prevention and control training courses.

The local management team in the centre attempted to clarify some of the training dates on the day of inspection and were in a position to identify staff who had attended fire training, however, due to the nature of the centre training log, inspectors were not assured that all staff have completed the required training or were scheduled for refresher training when needed.

Inspectors also attempted to review the supervision schedule for 2025, however, the centre did not have a schedule in place. Inspectors reviewed the supervision folder held in the centre and observed that to date in 2025, two supervisions only had taken place. In speaking with one staff member on the day of inspection, they confirmed to inspectors that it had been 18 months to two years since they last had supervision.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, there were systems in place to promote a safe environment for the residents and ensure care was delivered in person centered manner. However, some improvements were required in the application of these systems at a local level and in the timeliness of completing identified actions arising from provider audits.

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by a person in charge who was new to the centre. They were supported in their role by a service manager who was a Clinical Nurse Manager (CNM3). There were clear reporting structures in relation to reporting safeguarding concerns with a identified designated officer appointed to the centre.

A suite of local level audits were identified by the provider as being required however, inspectors were not presented with information demonstrating that these had been completed as outlined. The new person in charge was aware that gaps in auditing had been present and they were working to implement the required systems. The timeliness of completing actions where audits had occurred required improvements for example, repair to the ceiling in one house was identified as an action in May 2025 and this was outstanding on the day of inspection.

On review of the audits completed at provider level, the inspectors noted that they were occurring in line with the time lines set out in the Regulations. For example inspectors reviewed the six-monthly provider-led audit that occurred in February 2025 and the previous audit from October 2024. In line with the regulations the next provider-led audit was due in late August 2025. This audit was reported as completed and at the time of inspection the person in charge was awaiting the report. The provider's annual review of the service had been completed for 2024 and it had identified the requirement to ensure that staff training records were maintained and reviewed with five staff then noted as not having completed refresher safeguarding training. The gaps in staff training found on this inspection do not provide assurance that this action was addressed in a timely manner.

To ensure effective communication within the staff team regular team meetings were now in place. The inspectors reviewed the meeting notes for July and September 2025 and found that safeguarding was a standing agenda item on these meeting.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that the staff team were providing person centred care to the residents in this centre.The residents enjoyed the company of their peers in their respective houses and were encouraged to take part in activities in their community. They had busy active lives and were encouraged to take part in the running of their home. Some minor improvements were required in relation to the condition of the premises.

In terms of safeguarding there were good practices within the centre however, some areas, such as review of interim plans and ensuring clear guidance was in place for staff to follow required improvement to ensure it aligned with national policy and best practice in this area . Staff had sufficient knowledge in this area although some refresher training as stated was required. Residents were equipped with knowledge around the different types of safeguarding issues that they could encounter. There had been a discharge from the centre in recent months which had improved resident compatibility and reduced peer to peer safeguarding concerns. This ensured any safeguarding incidents that had occurred within the centre were well managed.

Regulation 10: Communication

Residents were assisted for the most part to communicate in accordance with their assessed needs and wishes. One area that required improvement was support of using Lámh (a manual signing system). All five residents were reported as using some Lámh signs and one communication passport had evidence of the signs used by the resident, however, no staff had been provided with training or had knowledge of Lámh signing.

The inspectors reviewed two residents' personal plans and found that each resident had a plan of care for communication and a communication passport in place. These documents accounted for each residents' specific way of communicating and were detailed. A speech and language therapist had signed off on communication care plans once they had reviewed the content. This included guidance on supports required from a communication partner, structured prompting and using objects of reference. This ensured the document was in line with the residents' needs notwithstanding the gap in manual signing as stated above.

Easy read information on safeguarding, advocacy, the complaints process and rights was available to the residents which helped support them to communicate their feedback on the quality and safety of care provided in the service. The residents told the inspectors how they made complaints if they were not happy with aspects of their care and support.

Residents also had access to telephones and other such media as Internet, televisions, radios and personal computers. For example, the inspectors saw that residents had televisions present in their bedrooms.

Judgment: Substantially compliant

Regulation 17: Premises

As previously described the designated centre comprises two adjoining and interconnected semi-detached homes in Dublin. The inspectors completed a walk around of all aspects of the designated centre. Overall, all parts of the centre were clean, warm and well presented although some improvements were required in relation to the timeliness of repairs and storage of bulk food/drink cans and bottles and staff belongings which were placed in the corner of the residents' conservatory.

Each house contained a kitchen-dining room and living room on the ground floor with three resident bedrooms and a staff office/sleepover room and bathroom on the first floor. To the rear of the houses a conservatory ran the width of both houses which was used by all residents. There was a small garden to the rear of the houses that also ran the width of both properties and this contained sheds for laundry facilities and storage.

Inspectors observed an area of damage to the ceiling of one living room and residents commented on it stating that this had 'happened a long time before' with another resident stating 'hole' and pointing up. Damage had occurred to the ceiling following a water leak in May 2025 and this had resulted in a small hole and black staining. The person in charge and staff reported that they had been told this could not be repaired until insurance funding was obtained and there were no timelines for this work available for review.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed two resident care plans on the day of inspection. Both care plans were found to be comprehensive in terms of clinical assessments and social goals. A comprehensive health assessment was in place for both residents, this health assessment then led to clinical care plans being formed on the basis of diagnosed medical conditions such as epilepsy, mental health and a heart condition. Inspectors found the subsequent care plans were clear in terms of guiding both nursing and non-nursing staff practices and supporting residents to continue to

access their local community. Where an assessed need was identified for additional behaviour support guidelines, the guidelines were in place, reviewed on a regular basis by an appropriate member of the MDT and also supported staff practice to ensure positive outcomes for residents.

Residents were supported in identifying meaningful social goals such as overnight stays away with family and attending events in their local community and inspectors found that key workers were providing regular updates on goal progression.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider and person in charge had ensured that residents were supported to achieve positive mental health which included support to manage behaviours that challenge if required.

Overall in the centre, residents required minimal support in the area of positive behaviour support. There were minimal restrictions in place in the designated centre. The reduction in the need for positive behaviour support occurred due to a resident having moved out of the centre to another home recently and the awareness that some residents required more individualised service which was being provided.

There were behaviour support plans in place for two residents. Additionally there were care plans in relation to behaviour support and risk assessments. The inspectors reviewed all these documents.The behaviour support plans had been updated in 2025 by the Behaviour Support Specialist and the care plans which included a traffic light system were also updated in 2025 by the person in charge.

In the behaviour support plan there was clear strategies in place to guide staff, including proactive, reactive and post incident strategies. The plans were formulated on a function based methodology to ensure it was in line with evidence based practice. There was very low level incidents in relation to behaviour support occurring in the centre indicating that the strategies and model of care was in line with residents' specific needs.

Judgment: Compliant

Regulation 8: Protection

The registered provider had implemented systems to safeguard residents, which were underpinned by a written policy. Staff had also completed safeguarding training to support them in the prevention, detection, and response to safeguarding

concerns. Staff spoken with were aware of the procedure for responding to and reporting safeguarding concerns.

There were a number of open safeguarding plans at the time of inspection. Inspectors reviewed documentation in place around these plans and found that some improvement was required in ensuring they were reviewed in line with the provider's and National policy. One resident had multiple interim safeguarding plans in place all of which referred to concerns arising from unexplained bruising. The multiple versions meant that different guidance was implemented following each incident and as an outcome staff were not clear on the specific steps in place for them to follow. For example one plan referred to the need for daily bruising checks which were to be documented, inspectors found this was not occurring and another plan did not refer to this requirement.

Intimate care plans had also been prepared to support staff in delivering care to residents in a manner that respected their dignity and rights. The inspectors reviewed two plans and found they identified the needs of each resident. For example, the plans described each residents preferences in how these needs were best met. However, for one resident there were two plans on file, as a previous version had not been archived, these were found to contain slightly conflicting information which did not assure that staff only had up-to-date guidance.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The centre had adopted good practices in ensuring residents' rights were considered and respected. Staff spoke with residents in a kind, respectful and dignified manner. Observations on the day of inspection indicated that residents were offered choice and control around their daily routine. These practices were embedded as part of residents' care plans to ensure best practice in this area.

Inspectors observed evidence of how choice and control was offered to residents across their daily routines with one resident showing inspectors how they framed their weekly timetable and left it on the windowsill to review with support when deciding what to do. Other residents when returning from activities were offered numerous options for what they wished to do or eat or watch on television with one resident choosing to lie with a blanket on the sofa and another choosing to spend time in their room. Residents were supported to complete preferred activities in their home at their request such as putting away laundry.

Residents met on a weekly basis and there was an effective system in place to communicate daily routines and changes in these routines was essential and good practice in relation to ensuring residents rights were well met. One resident held the role of human rights champion and they spoke to inspectors about how important this role was to them and spoke of their right to privacy.

There were easy-to-read documentation available to residents. The inspectors saw easy read documents in place around, their contract of care and associated charges and complaints. This ensured residents were informed of their rights around these aspects of care and support.
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	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ashington Group - Community Residential Service OSV-0003979

Inspection ID: MON-0048289

Date of inspection: 30/09/2025

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Provider will ensure the PIC has a schedule in place within the centre to ensure all staff are in receipt of supervision. These meetings will be documented and accessible by the PIC / PPIM within the centre. • The PIC will ensure a training schedule is in place and maintained appropriately. The training schedule will detail include training dates and scheduled dates for all staff working within the centre. • The PIC/ PPIM will ensure all training is in line with the needs of the centre.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The PPIM and PIC will review actions from previous and current unannounced audits to ensure all actions are addressed. • The PIC and PPIM will ensure that all audits within the centre are aligned with weekly, monthly , 6 monthly time frames. • The PPIM will review audits during monthly meetings to ensure actions are addressed. This is a standing agenda for PIC/ PPIM meeting. • The Provider will undertake 6 monthly unannounced audits as per regulatory requirement.	

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• The staff team will be supported to communicate with residents in line with the residents' needs and wishes.
• Staff will be provided with training within the centre in communicating via Lamh.
• A speech and language therapist will provide training to the team regarding communication.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Provider will ensure a record of all maintenance work is maintained
• All repairs within the centre will be carried out in a timely manner.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC and PPIM will ensure all documentation with the care plan is up to date and archive records in line with the records management policy
• The PIC and MDT will ensure safeguarding plans are maintained and up to date plans are located within plans of care.
• The PIC will ensure support required for safeguarding plans are communicated with the team within the centre.
• The PIC /PPIM will review safeguarding plans during monthly meetings.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/01/2025
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.	Not Compliant	Orange	31/01/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/01/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/12/2025

	are of sound construction and kept in a good state of repair externally and internally.			
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	31/12/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	28/02/2026
Regulation 23(3)(a)	The registered provider shall ensure that effective	Substantially Compliant	Yellow	28/02/2026

	arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	31/01/2026