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

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| Name of designated centre: | Castlefield Group - Community Residential Service |
| Name of provider: | Avista CLG |
| Address of centre: | Dublin 15 |
| Type of inspection: | Unannounced |
| Date of inspection: | 21 July 2026 |
| Centre ID: | OSV-0005237 |
| Fieldwork ID: | MON-0050968 |

## About the designated centre

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

Castlefield group is a community residential service providing adult residential accommodation for up to nine ladies and gentlemen with intellectual disabilities across two residential locations in West Co. Dublin. The houses are close to a variety of local amenities such as hairdressers, beauticians, pharmacy, shops, pubs, churches and parks. The first location currently provides accommodation for five ladies, and the second for four gentlemen. The first house house is a six bedroom semi-detached house in a cul-de-sac. There is a kitchen/dining room, sitting room, downstairs toilet and a main bathroom upstairs. The second location is a semi-detached house on a small cul-de-sac. It comprises of five single occupancy bedrooms one of which is used as a staff office and sleepover room. There is a kitchen/dining room, sitting room, downstairs toilet and a main bathroom upstairs. Residents are supported by a person in charge, social care workers and healthcare assistants, and staff support is available 24 hours a day, seven days a week. The staff team provides a variety of supports for residents who in some cases are of an aging profile.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 7 |

## 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 21 July 2026 | 08:50hrs to 17:00hrs | Kieran McCullagh | Lead |

## What residents told us and what inspectors observed

This report outlines the findings of an unannounced risk-based inspection of this designated centre. The inspection was conducted to assess compliance with the regulations, following the receipt of unsolicited information to the Office of the Chief Inspector of Social Services. From what residents told us and the inspector observed, it was evident that residents living in this designated centre were in receipt of high quality care and support, were happy, and felt safe living in their home. However, improvements were required in relation to positive behaviour support and the management of transition. Additionally, some minor improvements were required in relation to staffing and aspects of governance and management.

The inspection was conducted over a single day by one inspector. The person in charge facilitated the inspection by speaking with the inspector and promptly providing all requested documentation. The designated centre was comprised of two houses, located a short drive from each other. One house could accommodate four residents, and the other home could accommodate five residents. At the time of inspection, three residents were living in one house with one vacancy, while four residents were living in the second house with one vacancy. A fifth resident was due to move in at the end of July 2026. The inspector visited both homes that made up the designated centre, and had the opportunity to meet and speak with seven residents.

Care and support to residents was provided by a team of social care workers and healthcare assistants. At the time of this inspection, the designated centre was operating with a 0.5 whole time equivalent (WTE) deficit. The registered provider had suitable contingency plans in place and a small panel of relief and agency staff were used to cover vacant shifts. During this inspection, the inspector had the opportunity to meet and speak with three staff members.

The designated centre was managed by a full-time person in charge. They were found to be suitably skilled, experienced, and qualified for their role. The person in charge was not supernumerary to the roster, however, they had a total of 19.5 protected management hours, which allowed them fulfill their managerial responsibilities. The inspector found that the person in charge demonstrated they could meet their regulatory responsibilities.

The inspector completed a walkthrough of both houses that made up the designated centre accompanied by the person in charge. The first house visited by the inspector was comprised of four resident bedrooms (one had en suite facilities), a living room, a kitchen / dining room, a utility room, a staff bedroom / office, and two bathrooms. The inspector noted that the house was clean and tidy. The living space was was personalised and reflective of the residents' personalities and interests. For example, photographs of residents were displayed throughout the home, and residents' personal belongings including teddy bears, and art materials was accessible and

kept in communal areas. The inspector noted a warm and welcoming atmosphere in the home.

Each resident had their own bedroom, which was decorated according to their personal style and preferences. For example, bedrooms featured family photos, artwork, soft furnishings, and memorabilia that reflected their individual tastes and interests. One resident recently moved into a bigger bedroom, which better met their assessed needs and allowed for more storage of their personal belongings. The resident had recently moved into the designated centre in April 2026. They appeared very content in their new home, and already built a good rapport with their co-residents and the staff that supported them. The resident showed the inspector some of their teddy bears, which were in sitting room, along with an arts and crafts desk that had been set up for them. The resident happily chatted with the inspector, staff and co-residents before leaving for their day service program.

The inspector met and talked to two other residents. Both residents had plans to go out for the day. They sat and chatted with the inspector about their hobbies and interests, and told the inspector about a recent holiday they had been on to Liverpool. They enjoyed a trip to the zoo, a visit to a famous football club, shopping and a night out while there. One resident spoke to the inspector about their job before they retired. They worked as a gardener and told the inspector they really enjoyed their job. They had been employed for a long time and made a lot of friends while there. They showed the inspector a photo album with pictures of their friends and family, and told the inspector they met up regularly.

The second house was comprised of five resident bedrooms (two had en suite facilities), a large kitchen / dining room, two living rooms, a utility room, a staff office and two bathrooms. To the rear of the house was a well maintained garden with a small storage shed. Residents had painted colorful murals on the shed, and the garden was observed to be well maintained. One resident told the inspector they could look inside their bedroom. The bedroom was was clean and tidy and decorated in line with the resident's personal tastes and preferences. The resident told the inspector they loved their bedroom and they did not want to change anything about it.

The inspector sat in the kitchen, which was the main hub and social space used by the residents. All four residents sat and chatted with the inspector. One resident told the inspector they had two jobs. They had been working in a large well known supermarket for many years and really enjoyed working there. They also worked in a caring role, and told the inspector they enjoyed caring and helping to look after people. They showed the inspector photos and videos of a recent holiday they had been on in Wexford. They also informed the inspector they went home every weekend to stay with family. The resident told the inspector they were very happy living in their home and felt safe.

Other residents showed the inspector video montages of recent birthday celebrations the person in charge had put together. It was apparent to the inspector that all residents got along very well with each other. They chatted together about upcoming events including a summer barbecue and a birthday party they had all

been invited to. One resident sang a song for the inspector and was encouraged and supported by staff on shift to talk about their hobbies and interests. Staff working with the residents were very knowledgeable of residents' likes and dislikes, and it was noted that all residents enjoyed being in the staff members company.

The inspector observed that residents in both homes could access and use available spaces both within the centre and garden without restrictions. There were a small number of restrictive practices in place. These were logged on a restrictive practice log maintained by the person in charge, and notified to the Chief Inspector in line with the regulations.

Staff spoke with the inspector regarding the residents' assessed needs and described training that they had received to be able to support such needs, including safe administration of medication. The person in charge spoke highly of the standard of care provided to all residents and had no concerns regarding the safeguarding or wellbeing of anyone living in the designated centre. Observations carried out by the inspector, interactions with residents, feedback from staff, and documentation reviewed provided suitable evidence to support this.

The management team were well informed of the residents' needs and were clearly committed to driving continuous service improvements in order to ensure that residents were in receipt of a very good quality and person-centred service. Overall, this inspection found that the designated centre was providing individualised care and support where the rights of each resident was respected and where they were supported to live busy and active lives of their choosing.

The next two sections of the report will describe the oversight arrangements and how effective these were in ensuring the quality and safety of care.

## Capacity and capability

This unannounced inspection was carried out following receipt of solicited information which raised concerns in relation to governance and management, safeguarding of residents, residents' rights, and transition of residents. Ultimately, this inspection found that the management systems in place were effective in overseeing risks within the service. It ensured that residents were safeguarded and were in receipt of a high-quality, person-centred service. However, improvements were required regarding staff rosters, and the registered provider's six monthly audits.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the designated centre. There was a regular core staff team in place and they were very knowledgeable of the needs of the residents and had a good rapport with them. The staffing levels in place in the designated centre were suitable to meet the assessed

needs and number of residents living there. Warm, kind and caring interactions were observed between residents and staff, and staff were observed to be available to residents should they require any support and to make choices. However, improvements were required concerning the staff rosters, specifically regarding the recording of the full names of relief staff members on duty.

Appropriate training is fundamental in supporting staff to understand behaviours that challenge and promoting environments that respect residents' rights and dignity. The staff team had access to regular refresher training and there was a high level of compliance with mandatory training. Staff had received additional training in order to meet residents' assessed needs. All staff were supported and given sufficient time to receive training in safeguarding in order to provide safe services and supports to residents. All staff were in receipt of regular informal support and supervision, as per the registered provider's established supervision policy.

Some improvements were required in relation to the governance and management systems in this designated centre. Specifically, improvements were necessary regarding the registered provider led six monthly auditing systems and reports. The registered provider had completed an annual report of the quality and safety of care and support in the designated centre for 2025, which included consultation with all residents and their families and representatives. Overall, it was found that the designated centre was well governed and that there were systems in place to ensure that risks pertaining to the designated centre were identified and progressed in a timely manner.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

## Regulation 15: Staffing

Overall, improvements were required to the recording of relief staff used to back fill vacant shifts.

The designated centre was managed by a full-time person in charge. On the day of this inspection the registered provider ensured there were sufficient staffing levels with the appropriate skills, qualifications and experience to meet the assessed needs of the residents at all times, in accordance with the statement of purpose, and the size and layout of the designated centre.

The staff team was comprised of the person in charge, social care workers and healthcare assistants. The inspector reviewed the planned and actual staff rosters for April, May, and June 2026. It was found that regular staff were employed ensuring continuity of care for all residents. At the time of this inspection the designated centre was operating with a 0.5 whole time equivalent (WTE) deficit. However, the registered provider and person in charge had suitable contingency

plans in place to ensure continuity of care to all residents. For example, a small panel of regular agency and relief staff were used to cover vacant shifts.

During the inspection, the inspector spoke with three staff members on duty and found that they were very knowledgeable about the residents' support needs and their responsibilities in providing care. Residents were familiar with the staff and appeared very comfortable interacting and receiving care. It was clear that staff had developed and maintained therapeutic relationships with residents, helping them feel safe, secure and protected from all forms of abuse.

As previously mentioned, improvements were required to the recording of relief staff used to back fill vacant shifts. For instance, there were a number of occasions in which the full name of the relief staff was not recorded. This required enhancement to ensure the registered provider and person in charge had easy access to accurate and up-to-date staff rosters.

Schedule 2 staff files were not reviewed as part of this inspection.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

Staff had received appropriate training and education, ensuring they had the necessary knowledge and skills to effectively meet the residents' assessed needs.

The inspector completed a review of the staff training matrix which confirmed that all staff had completed a comprehensive range of training courses, ensuring they possessed the necessary knowledge and skills to effectively support residents. This included mandatory training in critical areas such as fire safety, managing challenging behaviour, and safeguarding vulnerable adults.

In addition, and to enhance quality of care provided to residents, further training was completed, covering essential areas such as safe administration of medication, basic life support, food safety, Children First, and manual handling.

The registered provider and person in charge had appropriate supervision arrangements in place for all staff. All staff received support and supervision relevant to their roles from appropriately qualified and experienced personnel in line with the registered provider's established policy. As per the registered provider's established supervision policy, all staff were to receive supervision on a bi-annual basis. The person in charge maintained supervision records and schedules, and the inspector reviewed two staff members' supervision records. It was noted that supervision meeting minutes included discussions regarding safeguarding, residents' needs, a review of each staff members' personal development, and provided an opportunity for them to raise any concerns.

Judgment: Compliant

## Regulation 23: Governance and management

The registered provider had effective systems in place to ensure the delivery of a safe, high-quality service to residents, fully aligned with national standards and guidance. However, improvements were necessary regarding the effectiveness of the registered provider's auditing systems. Specifically, enhancements were required regarding the register provider led six monthly unannounced visits and reports.

The inspector reviewed the registered provider led six monthly unannounced reports, and noted that these were not in line with regulatory requirements. For instance, one unannounced visit was completed in May 2025, while the next visit took place in December 2025. This was outside of the specified time frame, as outlined under the regulations. In addition, the inspector found that these audits were not operating effectively. For example, one audit documented that positive behaviour support plans were complete and were up-to-date. However, there were no positive behaviour support plans on file for residents. In addition, the inspector noted that the report following the most recent six month unannounced visit conducted in June 2026, had not yet been completed. Actions identified as part of this report had not been made available to the person in charge, and therefore improvements where required could not be progressed or implemented. This required review and consideration by the registered provider.

There was clear evidence of consistent oversight and monitoring of the care and support provided within the designated centre, with regular management presence on-site. Adequate arrangements were in place to ensure effective oversight and operational management during periods when the person in charge was off duty or absent. Additionally, clear and well-communicated on-call arrangements provided staff with access to managerial advice at all times, as needed.

An annual review of the quality and safety of care was completed for 2025. The inspector noted that all key stakeholders had been actively consulted as part of the review process, as per the regulatory requirement. Furthermore, a number of local audits had been completed to measure the service performance against the national standards, and to identify any areas for ongoing improvement. Additional audits carried out included infection prevention control (IPC), fire safety, restrictive practices, health and safety, residents' finances, and residents' medicines. These audits identified any areas for service improvement and action plans were derived from these.

Judgment: Substantially compliant

## Quality and safety

This unannounced inspection was carried out following receipt of solicited information which raised concerns in relation to governance and management, safeguarding of residents, residents' rights, and transition of residents. The inspector found that all residents were in receipt of high quality care and support. However, improvements were necessary regarding the transition and discharge of residents and positive behavioural supports.

Enhancements were required regarding the registered provider's processes and protocols pertaining to the discharge and transition of residents. This inspection found that the recent transition of one resident to another designated centre operated by the registered provider was not carried out in accordance with the registered provider's admission, discharge, and transfer (ADT) policy. Furthermore, guidance set out in the resident's individual transition plan was not complied with. This necessitated considerable review by the registered provider.

The registered provider had failed to ensure that residents with identified positive behavioural support needs had access to appropriate and structured supports. As a result, some residents were at risk of exhibiting high-risk behaviours, including potential self-injury, and staff were left without the vital guidance or tailored support strategies required to effectively intervene and promote safer, positive outcomes within the designated centre.

The registered provider and person in charge were endeavouring to ensure that residents living in the designated centre were safe at all times. Good practices were in place in relation to safeguarding. Any incidents or allegations of a safeguarding nature were investigated in line with national policy and best practice. The inspector found that appropriate procedures were in place, which included safeguarding training for all staff, the development of personal intimate care plans to guide staff, and the support of a designated safeguarding officer within the organisation.

The inspector saw that staff practices in the designated centre were upholding residents' dignity, and were supporting residents to have control over their lives. Residents were continually consulted about and made decisions regarding the ongoing services and supports they received, and their views were actively and regularly sought. Information was made available to residents in a way that they could understand in order to support them to make informed choices and decisions.

## Regulation 25: Temporary absence, transition and discharge of residents

This inspection found the the registered provider failed to adhere to it's own established admission, discharge and transfer (ADT) policy.

One resident had recently been discharged from the designated centre and transitioned to another designated centre operated by the registered provider in

June 2026. However, the registered provider failed to ensure that the resident's discharge and transition was in line with protocols outlined in their ADT policy. Specifically, the inspector noted that the resident did not have an individualised transition plan in place, which was prepared and "executed in a timely manner" as directed in the registered provider's policy. Furthermore, the resident did not have access to an advocate in the development of the transition plan.

The inspector was informed by the person in charge and service manager that the resident was told about their transition the day before it happened. In addition, the resident had visited their new home the day before their intended transition, which was not line with guidelines as set out in the resident's transition plan. The inspector completed a thorough review of the resident's transition plan which stated:

- Phased transition supports to include a number of initial visits prior to moving in
- Sleepover / Overnight supports
- An advocate referral to be progressed to support resident in relation to the move, and future planning.

As stated above, the resident was informed of the transition the day before, meaning a phased transition or opportunity for sleepover or overnight supports was not made available. In addition, on the day of this inspection a referral to an external advocate for further supports had not yet been progressed.

Processes and protocols in place regarding discharge and transfer of residents required thorough review and consideration by the registered provider.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

The inspector reviewed the arrangements in place to support residents' positive behaviour support needs and found that the registered provider had failed to provide all residents with timely and effective positive behavioural support in line with their assessed needs.

On the day of inspection, it was found that one resident with assessed positive behavioural support needs did not have formal positive behaviour support plans on file. The inspector was informed and saw evidence on file that the resident presented with a risk of engaging in behaviours that challenge especially when feeling anxious. Potential triggers included activity plan changes and unfamiliar staff which could lead the resident to engage in self-injurious behaviour, repetitive questioning, and self-induced vomiting. Furthermore, the inspector's review of recent multidisciplinary meeting minutes documented increased anxiety which led to the resident becoming physically unwell.

The lack of formal positive behaviour support plans meant that the staff team did not have up-to-date information on antecedents, proactive strategies, reactive strategies, and detailed behavioural background information. As a result, a thorough review and action was required from the registered provider and person in charge to address this and minimise the risk of behaviours that challenge.

Judgment: Not compliant

## Regulation 8: Protection

The inspector noted that the registered provider had effective arrangements to safeguard residents from abuse in place, such as staff training, appropriate staffing levels, and reporting systems.

All safeguarding concerns had been reported, responded to, and managed in line with the registered provider's established policy. Safeguarding incidents were notified to the safeguarding team and to the Chief Inspector in line with regulations. The inspector found that when concerns arose, measures were implemented to protect residents from further abuse.

At the time of this inspection, there were no open safeguarding concerns. The inspector noted that all previous safeguarding concerns had been reported and responded to as required. For example, informal safeguarding plans had been prepared with appropriate actions in place to mitigate safeguarding risks. The inspector reviewed two previous preliminary screening forms, and found that any incident, allegation or suspicion of abuse was appropriately investigated in line with national policy and best practice. Information included in preliminary screening forms was comprehensive and accurate.

Staff spoken with throughout this inspection were knowledgeable about abuse detection and prevention and promoted a culture of openness and accountability around safeguarding. In addition, staff knew the reporting processes for when they suspected, or were told of suspected abuse. It was evident that staff took all safeguarding concerns seriously.

Following a review of three residents' care and support plans, the inspector observed that safeguarding measures were in place to ensure that staff provided personal and intimate care to residents who required such assistance in line with their personal plans, and in a dignified manner.

Judgment: Compliant

## Regulation 9: Residents' rights

There was evidence that the designated centre was operated in a manner that respected residents' rights, needs, and choices, thereby supporting their welfare and promoting self-development.

The inspector observed that staff interactions with residents were in a manner which upheld residents' dignity and provided residents with choice and control. Staff were seen offering residents choices, responding to residents needs and requests by providing direct assistance in a manner which respected residents' right to dignity and privacy.

Residents attended resident meetings where they discussed activities, menus, and plans for the week ahead. In addition to the residents' meetings, they also had individual keyworker meetings where they were supported to choose and plan personal goals.

Overall, it was clearly demonstrated that residents received a high standard of support, person-centred, and rights-informed care, which was upholding their human rights. Residents were observed to engage in meaningful activities in line with their assessed needs, likes and personal preferences throughout the inspection.

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 | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 25: Temporary absence, transition and discharge of residents | Not compliant |
| Regulation 7: Positive behavioural support | Not compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Castlefield Group - Community Residential Service OSV-0005237

## Inspection ID: MON-0050968

## Date of inspection: 21/07/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>The person in charge will ensure that the planned and actual staff roster clearly records the full name of every staff member working within the designated centre, including relief and agency staff. Where agency staff are utilised, the relevant agency will also be clearly identified.<br><br>All staff responsible for completing or amending the roster will be reminded of this requirement.<br>The person in charge will review the actual roster on a weekly basis to ensure that the full names of all staff members on duty are recorded and that the roster accurately reflects the staffing arrangements within both locations.<br><br>This requirement will form part of ongoing local governance checks to ensure continued compliance with Regulation 15. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>The registered provider will strengthen oversight arrangements for the completion of six-monthly unannounced provider visits to ensure that these visits are undertaken within the timeframe required under Regulation 23. | |

A schedule and tracking system will be maintained by the registered provider which clearly identifies when each six-monthly unannounced visit is due. This will be monitored to ensure that the regulatory six-month timeframe is not exceeded.

The quality assurance process associated with the provider-led visits will be strengthened to ensure that findings recorded within reports are verified against the documentation and practice operating within the designated centre.

Actions arising from provider-led visits will identify the person responsible for completing the action and the required completion date. Actions will be incorporated into the centre's local quality improvement/action plan and reviewed by the PIC and PPIM on a monthly basis until completed.

The person in charge will ensure that evidence of completed actions is maintained within the centre and available for subsequent provider-led visits and regulatory review.

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| Regulation 25: Temporary absence, transition and discharge of residents | Not Compliant |

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
The registered provider and person in charge will review arrangements relating to the admission, transition, transfer and discharge of residents to strengthen the governance and documentation of both planned transitions and transitions required within an urgent timeframe due to safeguarding or other compelling reasons. They will also ensure that all transitions, admission and discharges are completed in line with Avista's policy.

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| Regulation 7: Positive behavioural support | Not Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The person in charge will ensure that residents with identified positive behavioural support needs have appropriate, current and individualised positive behaviour support guidance available to staff.
The resident identified during the inspection has been referred to the Positive Behaviour Support service and has now been seen by the relevant clinician. A specialist assessment is currently underway to inform the development of an individualised positive behaviour

support plan.
The person in charge will also review the assessed behavioural support needs of all residents within the designated centre. Where a resident is identified through assessment, multidisciplinary review, incident review or changes in presentation as requiring specialist positive behaviour support input, an appropriate referral will be progressed in a timely manner. Pending specialist assessment, appropriate interim guidance will be developed so that staff have clear and consistent strategies available to support the resident.
Staff are booked to complete the two-day Managing Signs of Distress training course to further develop their knowledge and skills in recognising and responding appropriately to behaviours of distress.

## 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 | 30/09/2026 |
| Regulation 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any | Substantially Compliant | Yellow | 31/10/2026 |

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| | concerns regarding the standard of care and support. | | | |
| 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 | 30/09/2026 |
| Regulation 25(4)(a) | The person in charge shall ensure that the discharge of a resident from the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose. | Not Compliant | Orange | 30/09/2026 |
| Regulation 25(4)(b) | The person in charge shall ensure that the discharge of a resident from the designated centre take place in a planned and safe manner. | Not Compliant | Orange | 30/09/2026 |

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|---|---|---|---|---|
| Regulation 25(4)(d) | The person in charge shall ensure that the discharge of a resident from the designated centre is discussed, planned for and agreed with the resident and, where appropriate, with the resident's representative. | Not Compliant | Orange | 30/09/2026 |
| Regulation 07(1) | The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. | Not Compliant | Orange | 30/11/2026 |