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:	Kinvara Group-Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 7
Type of inspection:	Unannounced
Date of inspection:	14 April 2026
Centre ID:	OSV-0005729
Fieldwork ID:	MON-0046484

About the designated centre

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

Kinvara Group Community Residential Services comprises two houses based within walking distance of each other in a suburban area of Dublin. The centre provides care and support for four residents in each of the houses. Residents in one house have low support needs, while residents in another house have medium to high support needs. Staff teams in each of the houses consist of social care workers and care assistants. The provider states that their vision is for people to live their best lives as active citizens in an inclusive society.

The following information outlines some additional data on this centre.

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 14 April 2026	09:00hrs to 17:45hrs	Kieran McCullagh	Lead
Tuesday 14 April 2026	09:00hrs to 17:45hrs	Orla McEvoy	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the ongoing regulatory monitoring of the designated centre, and focused on how residents were being safeguarded. Regulations pertaining to safeguarding were specifically assessed as a part of this inspection. Inspectors determined that residents received high-quality care provided by a familiar staff team who delivered it with kindness and respect. However, there were areas of non-compliance found relating to governance and management, and risk management procedures. Furthermore, improvements were required under a number of other regulations, including staffing, premises, individualised assessment and personal planning, and positive behavioural support. This is discussed further in the main body of the report.

The inspection was carried out over a single day by two inspectors, and was facilitated by the person in charge. To assess the quality of life for the residents inspectors relied on a combination of observations, discussions with residents, a thorough review of relevant documentation, and conversations with key staff members.

The designated centre is comprised of two properties in close proximity to each other, located in Dublin. The designated centre is located within walking distance of shops, restaurants, and public transport links. The designated centre is registered to accommodate eight adults, with four residents living in each premises. At the time of this of this inspection there were seven residents living in the designated centre. Over the course of the day, inspectors had the opportunity to meet and talk to six residents. In addition, inspectors met with the person in charge, service manager, and person participating in management.

According to the designated centre's statement of purpose, its aim was to "create a homely environment which promotes independence, choice and participation of the resident in all aspects of their life". The designated centre strived to work together with residents "to live their best lives through the delivery of quality services".

One premises was home to three residents. It is a three-storey terraced property, with five bedrooms, one of which is the staff sleepover room / office. The downstairs of the house is comprised of two sitting rooms, a kitchen / dining room, and an accessible bathroom. To the rear of the premises there is a large garden and patio area, with seating for residents to use as they so wish. Inspectors observed a large shed located in the area, and were informed by the person in charge and a member of staff, of the presence of a toxic substance in the roof of the shed, and were informed that residents do not use this space. Inspectors observed that the entrance to the shed had been boarded up. However, overtime this had been damaged, and required repair to prevent the risk of someone entering.

The other premises was home to four residents. The property is a terraced house, and is comprised of four bedrooms, one of which is located on the ground floor, a large kitchen / dining room, a utility room, a living room, and two bathrooms. To the rear is a large garden with an accessible ramp, and seating.

Inspectors completed a walk-through of both premises accompanied by the person in charge. Overall, inspectors observed that the designated centre was clean, and well-maintained. Some maintenance issues were observed in one property, and these are discussed in full under Regulation 17: Premises.

Residents had their own bedrooms, which allowed for personal space and privacy, while communal areas were found to be spacious, and thoughtfully arranged to encourage social interaction and relaxation. The overall interior decor and furnishings were tasteful, and well maintained, contributing to a warm and inviting environment. Kitchens across both homes were well equipped, and supported a diverse and balanced selection of food and drinks, which catered to residents' dietary needs and preferences.

Inspectors also observed fire detection and fire fighting equipment throughout the homes, and individualised evacuation plans were available to guide staff on the supports required by residents. However, inspectors also noted that fire evacuation routes were blocked, which impeded residents' ability to safely and promptly evacuate in the event of an emergency. The person in charge was issued an immediate action to clear evacuation routes, and inspectors noted that was completed by the end of the inspection.

Inspectors met and spoke to six residents during the course of this inspection. All residents led active and busy lives. Their daily routines were individualised, and aligned with their own personal interests and preferences. Their independence within their home and community was promoted, encouraged, and supported by the staff working with them. Many of the residents accessed the local community independently. Some residents told inspectors they enjoyed attending knitting classes, using the local swimming pool, going shopping, meeting friends for lunch, attending day service programs, attending retirement clubs, and spending time with family members.

Residents spoke about their engagement in household chores, in line with their own interests and abilities. Some residents were retired, and spoke about previous valued work roles including helping with the laundry in another residential service. All residents told inspectors they were very happy living in their home, and felt safe. They had no concerns or complaints, but said that they would speak with staff if they had any issues or concerns.

Throughout this inspection, residents appeared comfortable and at ease talking with inspectors, and interacting with staff, demonstrating a relaxed and happy demeanor in their home. It was evident that they had a strong rapport with the staff who supported them. The designated centre itself presented as a calm, relaxed environment, free from any sense of restriction.

Inspectors found that there were effective arrangements for residents to be consulted with, and express their views and wishes. They made decisions on a daily basis about their lives, and also attended weekly house meetings, and key worker meetings where they discussed relevant topics about the designated centre, and reviewed their personal goals. Inspectors reviewed a sample of the residents' house meeting minutes from April 2026, and noted that residents discussed important topics including infection prevention and control (IPC), activities they wanted to partake in, complaints, safeguarding, what staff were on duty, and menu plan for the week.

Inspectors spoke with three staff members over the course of the inspection. Inspectors noted that staff working in the designated centre were skilled, and knew the residents' likes and preferences. They had completed training equipping them with the skills and expertise required to support the residents. In addition, all staff had completed safeguarding training, and were aware of the procedures for reporting any concerns. Over the course of the inspection, inspectors observed staff supporting the residents in a professional, person-centred, and caring manner at all times.

From speaking with residents and observing their interactions with staff, it was evident that they felt very much at home in the designated centre, and were able to live their lives and pursue their interests as they chose. The service was operated through a human rights-based approach to care and support, and residents were being supported to live their lives in a manner that was in line with their needs, wishes, and personal preferences.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Safeguarding is a critical responsibility for registered providers in designated centres. All residents have the right to safety, and to live free from harm, which is essential for delivering high-quality health and social care. Residents should be able to trust the registered provider, person in charge, and the staff to help them feel secure. Therefore, effective safeguarding depends on collaboration among individuals and services to ensure that residents are treated with dignity and respect, and are empowered to make decisions about their own lives.

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 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 practical support and support to make decisions. 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 all residents. Inspectors spoke with a number of staff over the course of the inspection, and found that they were well-informed regarding residents' individual needs, and preferences in respect of their care.

During the course of this inspection, inspectors observed a number of critical areas where the governance and management structures appeared inadequate. Specifically, improvements were required regarding registered provider led six monthly unannounced visits and reports, annual review of care and support, local auditing systems, and staff team meetings. Gaps in documentation and inaccurate reporting indicated a lack of effective oversight.

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

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. Inspectors noted that the staff team were well qualified, and dedicated to delivering care that upheld residents' rights, and ensured their safety.

The staff team was comprised of the person in charge, social care workers, and healthcare assistants. Inspectors examined the planned and actual staff rosters for February, March, and April 2026. It was found that the registered provider was committed to ensuring continuity of care for residents within the service by utilising a small group of regular relief staff to cover vacant shifts. However, inspectors noted that improvements were needed in the staff rosters. In particular, the full names of

relief staff were not consistently recorded, and in some cases, the name of the relief staff was entirely missing. As a result, the person in charge was unable to identify who had covered certain vacant shifts. This area required improvement by the person in charge to ensure rosters were accurate, complete, and consistently maintained within the designated centre.

In addition, inspectors noted that two staff members garda vetting had expired. Staff members required re-vetting to ensure all information was up-to-date.

During the inspection, inspectors spoke with three staff members on duty, and found that all were highly knowledgeable about the residents' support needs and their responsibilities in providing care. Residents were familiar with the staff team, and felt 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.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Effective systems for recording and monitoring staff training were implemented, ensuring staff were well-equipped to provide quality care. Examination of the staff training matrix evidenced that all staff members had completed a diverse range of training courses, enhancing their ability to best support all residents. This included mandatory training in fire safety, positive behavioural supports, and safeguarding, all of which contributed to a safe and supportive environment for the residents living in this designated centre.

In addition, and to enhance quality of care provided to residents, further training was completed, covering essential areas such as safe administration of medication, infection prevention and control (IPC), and manual handling.

Staff were in receipt of regular support and supervision from the person in charge. For example, staff participated in biannual formal supervision sessions. One inspectors review of five staff member's supervision records confirmed that each session included a review of continuous professional development, and provided a platform for staff to voice concerns, and provide feedback.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors noted that while clear lines of authority and accountability were in place within the designated centre, this inspection highlighted a number of key areas

where improvements were required in oversight and local management systems. Specifically, enhancements were required regarding the registered provider's six monthly unannounced visits, annual review of care and support, local management auditing systems, and staff team meetings.

Inspectors 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 most recent visit took place in January 2026. This was outside of the specified timeframe, as outlined under the regulations. Following review of reports maintained, inspectors found that improvements were needed regarding the accuracy of recorded and reported information. For instance, the report noted that information regarding Regulation 7: Positive behavioural support was not applicable. However, this inspection evidenced that one resident had an assessed positive behavioural support need, and restrictive practices were in use in both premises that made up the designated centre. Additionally, the most recent report noted that one safeguarding concern had been notified to the Office of the Chief Inspector. However, a total of five safeguarding concerns had been notified.

Furthermore, a number of identified actions from both reports remained outstanding on the day of this inspection. For example, actions identified regarding staff rosters, premises works, and monthly staff team meetings had not been completed or progressed. Action plans had not been reviewed or updated, and therefore inspectors could not determine if actions had been initiated or completed in order to drive continuous service improvement.

Inspectors reviewed the annual review of care and support for 2025, and noted that residents' families or their representatives were not consulted with, as required by the regulation. This required review and consideration by the registered provider.

Improvements were also required to weekly and monthly local auditing systems. Local audits were completed as part of governance arrangements, and covered critical areas such health and safety, fire, residents' finances, infection prevention and control (IPC), and vehicle checks. A review of audits completed by inspectors evidenced that auditing systems in place were not identifying risks regarding fire, health and safety, or the designated centre's vehicle. As a result, actions to address issues and risks were not in place or assigned to a person responsible.

The person in charge informed inspectors that monthly staff team meetings were intended to occur on a monthly basis. Upon request, inspectors reviewed the minutes of staff team meetings held at the designated centre across 2025 and 2026. Inspectors noted that only five staff team meetings had took place across 2025, and two staff meetings had occurred so far in 2026. This did not provide sufficient assurance to inspectors that all staff were being adequately updated and informed about the evolving needs of residents within the service, and this posed a risk to the staff members providing person-centred, safe, and effective support to residents.

Judgment: Not compliant

Quality and safety

This section of the report provides an evaluation of the quality of services delivered and the effectiveness of measures implemented to ensure the safety of residents. Regulations pertaining to safeguarding were specifically assessed as a part of this inspection. Overall, a good quality of service was provided to all residents, and during this inspection, inspectors observed residents expressing their choices to staff regarding what they wanted to do, and when they needed support. However, improvements were required in relation to individual assessment and personal plans, positive behavioural support, premises, and risk management procedures.

Staff were well informed about each resident's individual communication needs. Throughout the inspection, inspectors observed that staff demonstrated flexibility and adaptability in their use of various communication strategies. A strong culture of listening to and respecting residents' views was evident within the service. Residents were actively supported and encouraged to communicate with their families and friends in ways that suited their personal preferences.

The registered provider recognised that the premises can have a significant impact on residents' quality of life, including their changing needs over time. They took into account safeguarding measures and ensured that the facilities at the designated centre were appropriate for the number and assessed needs of the residents. This alignment was in accordance with the statement of purpose as required under Regulation 3. Inspectors found the atmosphere in the designated centre to be warm and relaxed, and residents told inspectors they were very happy living in their home, and with the support they received. However, a number of maintenance issues were identified that required attention including the renovation of one kitchen, and damage to a kitchen ceiling as a result of a leak.

Risk management procedures are crucial in ensuring residents and staff members safety and wellbeing. Inspectors were not assured that the registered provider or person in charge was identifying potential hazards, or had provided residents and staff with clear protocols to follow in the event of an emergency. Improvements were necessary to ensure the registered provider had clear and consistent processes in place for managing and assessing risk. Inspectors observed a number of risk related concerns relating to fire safety management arrangements, the designated centre's vehicle, controlling for risks associated with asbestos, and individual risk assessments.

Residents were in receipt of appropriate care and support that was individualised and focused on their needs. Residents were seen to be supported to access relevant healthcare appointments, and to live busy and active lives in line with their assessed needs and preferences. It was found that residents had comprehensive assessments of need on file. Care intervention plans were derived from these assessments of need. Care intervention plans were comprehensive, and were written in person-

centred language. Residents' needs were assessed on an ongoing basis, and there were measures in place to ensure that their needs were identified and adequately met. However, improvements were required to ensure all residents had up-to-date assessments of need and care intervention plans on file.

The registered provider had failed to ensure that there were appropriate positive behavioural supports available to residents who required such supports. Residents were presenting with behaviours that were of risk to their own and others safety. For instance, one resident had a history of making allegations against staff members, shouting, and engaging in behaviours that challenge. The registered provider and person in charge ensured that the service continually promoted residents' rights to independence, and a restraint-free environment. For example, restrictive practices in use were clearly documented, and were subject to review by appropriate professionals.

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. Inspectors found that appropriate procedures were in place, which included safeguarding training for staff, and the support of a designated safeguarding officer within the organisation.

Inspectors 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 10: Communication

The registered provider demonstrated respect for core human rights principles by ensuring that residents could communicate freely and were appropriately assisted and supported to do so in line with their assessed needs and wishes. Throughout the duration of the inspection, inspectors observed residents freely expressing themselves, receiving information and being communicated with in the best way that met their assessed needs.

The service fostered a culture of listening to and respecting residents' views and opinions. For instance, all residents were consulted with as part of the designated centre's annual review for 2025, and their views and positive feedback was included as part of the report. Positive feedback included one resident advising that the designated centre "couldn't be better", while other residents spoke about accessing the community independently. Residents also spoke about how they would raise a

complaint, as well as how they would advocate for themselves to staff and management.

All residents had access to music players, televisions, mobile phones, and technological devices in line with their needs and wishes. Throughout the inspection, inspectors observed residents actively engaging with these independently, and with the support from the staff team.

Residents communicated freely with inspectors, and told them that they really enjoyed living in their home, liked their staff team, and felt safe and happy.

Judgment: Compliant

Regulation 17: Premises

The registered provider had considered safeguarding in ensuring that both premises that made up the designated centre was appropriate to the number and assessed needs of the residents living in the designated centre, and in accordance with the statement of purpose prepared under Regulation 3. Inspectors observed that both premises conformed to the standards outlined in Schedule 6 of the regulations, with consideration given to the safeguarding needs of the residents living in each home.

Residents were able to freely access and use the available spaces within the designated centre, and its gardens. Facilities were well maintained and in good working order. There was sufficient private and communal space for residents, along with appropriate storage facilities.

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. This approach supported the residents' independence and dignity, while acknowledging their uniqueness. Additionally, every bedroom was provided with ample and secure storage for residents' personal belongings.

However, during the walk through of one of the premises that made up the designated centre, a number of maintenance issues were identified that required attention. These issues had previously been identified during the last inspection in 2024, and were also noted in the registered provider's own internal audits. Specifically, the kitchen required refurbishment. Inspectors observed damaged kitchen cabinets, chipped grouting, and visible deterioration of a number of walls. The kitchen ceiling required repairs due to damage sustained from a recent leak. Additionally repainting was required throughout the premises. These issues detracted from the welcoming atmosphere of the designated centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

On the day of this inspection, inspectors observed a number of risk related concerns that had not been appropriately managed or assessed. Specifically, risks pertaining to fire, the vehicle used to transport residents, the management of asbestos, and individual risk assessments, were identified.

Fire assembly point signage plays a crucial role in guiding occupants to safety during an emergency, and provides essential information that helps prevent panic, and ensures a smooth and orderly evacuation. During the walk around of both premises inspectors observed that the registered provider had not ensured fire assembly point signage was in place, which posed a potential risk to residents and staff in the event of an emergency evacuation. Residents spoken with on the day were unsure of where they should assemble in the event of an emergency. This required review by the registered provider.

In addition, inspectors observed that fire evacuation routes were obstructed, which created serious safety hazards, and put residents and staff at further risk. Inspectors issued an immediate action on the day to clear all evacuation routes. Inspectors noted that this had been completed by the end of inspection.

Inspectors noted that the designated centre's dedicated vehicle's tax had expired in October 2025. Information had not been made available to staff pertaining to exemptions for the transport vehicle, which put the registered provider and drivers of the vehicle at risk of on the spot fines and penalties. The registered provider informed inspectors that they were fully exempt from tax, however, there was no disc displayed on the vehicle to evidence same.

Inspectors were informed of the presence of asbestos in the roof of a shed to the rear of one property that made up the designated centre. However, the registered provider or person in charge had not ensured that a management plan was in place to monitor the condition, control for potential hazards. In addition, there was no signage in place to inform visitors, residents or staff of the potential hazard. This required considerable review and consideration by the registered provider.

Furthermore, inspectors noted that a number of residents' individual risk assessments were overdue review. For example, individual risk assessments relating to people handling, fire, finances, and falls all required review and updating.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The registered provider had arranged to meet the safeguarding needs of each resident, and the person in charge had ensured that safeguarding needs were part of all residents' assessments of need and of their review thereafter. However, improvements were required to ensure all residents had up-date assessments of need, and care intervention plans on file.

Assessments of need informed comprehensive care intervention plans, which were written in a person-centred manner and detailed residents' preferences and needs with regard to their care and support. For example, inspectors observed plans on file for residents relating to the following:

- Communication
- Diet
- Mobility
- Self-help skills.

However, one resident's assessment of need had not been reviewed since February 2025. Furthermore, a number of their care intervention plans including mental health, and general healthcare plans also required updating to ensure the most accurate and up-to-date information was available to staff in order to provide appropriate care and support.

Residents were supported to plan meaningful personal goals. Examples of goals included joining a class in the community. Residents were supported to break their goals into achievable steps, and documentation was available to demonstrate their progress, and their goal attainment.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Inspectors 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 current assessed needs.

One resident who had assessed positive behavioural support needs did not have a positive behaviour support plan on file on the day of this inspection. Inspectors were informed and saw evidence on file that the registered provider's behaviour support specialist advised that the resident did not meet the threshold for criteria on the positive behavioural support caseload. However, a review of multidisciplinary team meeting minutes from August 2025 and March 2026 documented that the resident had a history of making allegations against staff members, shouting at peers, and engaging in behaviours, such as spitting. This was of concern given the lone working arrangements within the designated centre, and staff did not have access to the necessary consistent supports to effectively implement positive behavioural

supports or respond appropriately to the behaviours that challenge. This required considerable review.

There were three restrictive practices in place within the designated centre. Inspectors completed a full review of these, and found they were the least restrictive possible and used for the least duration possible. Residents had consented to the use of restrictions. For example, restrictive practices were discussed during weekly resident meetings.

Inspectors found that the registered provider and person in charge were promoting residents' rights to independence and a restraints free environment. For example, restrictive practices in place were subject to regular review by the registered provider's multidisciplinary team, and where appropriate restrictive practice reduction plans were in place.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider and person in charge had established systems to safeguard residents from abuse. For instance, a clear policy was in place, providing staff with explicit guidance on the appropriate actions to take in the event of a safeguarding concern. Furthermore, all staff had completed safeguarding training equipping them with the skills necessary for the prevention, detection, and response to safeguarding issues.

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

At the time of this inspection there were no safeguarding concerns open. However, inspectors found that previous safeguarding concerns had been reported and responded to as required. For example, interim safeguarding plans had been developed with appropriate actions in place to mitigate safeguarding risks. One inspector reviewed two preliminary screening forms, and found that any incident, allegation or suspicion of abuse was appropriately investigated in line with national policy and best practice.

Residents experienced a service where they were protected and kept safe. They were empowered to express choices and preferences, and were involved in all aspects of decision-making in relation to safeguarding.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that the centre was operated in a manner that respected residents' rights, needs, and choices, thereby supporting their welfare, and promoting self-development. Some improvements were required to ensure residents were being supported to avail of all support arrangements to ensure their rights were being upheld.

The registered provider had fostered a culture where a human rights-based approach to care was central to how residents were supported. Throughout the inspection, the use of this approach was evident, empowering residents to live lives of their choosing, guided by human rights principles. For example, residents had control over their daily routines, making choices based on their personal values, beliefs, and preferences. Inspectors noted 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 and participated in weekly resident meetings. A review of the April 2026 resident meeting minutes evidenced that they discussed activities, menus, restrictive practices, health and safety, and fire safety. In addition to the residents' meetings, they also had individual key worker meetings where they were supported to choose and plan personal goals.

Residents had contracts of care in place, which were signed by residents, and clearly outlined important information pertaining to payment of fees, and services not included in the fees.

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	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kinvara Group-Community Residential Service OSV-0005729

Inspection ID: MON-0046484

Date of inspection: 14/04/2026

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: The PIC will complete roster Audits on a weekly basis. The PPIM will complete quarterly roster audits. HR will complete a full review of the Designated Centre's personnel files.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Nominee Provider will ensure that the registered provider's six monthly unannounced visits are completed accurately and in line with the regulations. The PIC and PPIM will review the compliance log at their monthly governance meetings. The PIC will ensure all audits are completed as per the Avista audit schedule. The PIC has completed a schedule for monthly team meetings for the remainder of 2026. The Nominee Provider will ensure that all families are given the opportunity to complete the annual satisfactory survey.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Nominee Provider will ensure that all maintenance issues within the Designated Centre are rectified.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures:	

The nominee provider will collaborate with the Director of Property, Estates & Technical Services to devise and implement a management plan to monitor the condition of the asbestos roof and put appropriate control measures in place to manage any potential risks.
The PIC will ensure that fire evacuation routes are free from obstruction at all time and will include it as an item on the agenda of team meetings.
The PIC will ensure that Fire assembly points are discussed as meetings with supported individuals as a standing agenda with visual supports included. The Nominee Provider will measure the residents ability to evacuate to the Fire assembly point by reviewing the ongoing evacuation reports.
The PIC will ensure that anything noted on the weekly 'walk about' audit will be escalated by staff completing same to allow for appropriate action plan.
The PIC will ensure all residents risk assessments are kept up to date.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC will ensure that all personal plan are reviewed and kept up to date.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC will review the referral to positive behaviour support with the positive behaviour support team.

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	31/05/2026
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	30/09/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/10/2026

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.	Not Compliant	Orange	30/09/2026
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	31/10/2026
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 concerns regarding the standard of care and support.	Not Compliant	Orange	31/10/2026

Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/09/2026
Regulation 26(3)	The registered provider shall ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.	Not Compliant	Orange	30/09/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently	Substantially Compliant	Yellow	30/09/2026

	than on an annual basis.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	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.	Substantially Compliant	Yellow	30/09/2026
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/09/2026