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: | Avondale |
| Name of provider: | St John of God Community Services CLG |
| Address of centre: | Co. Dublin |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 27 August 2025 |
| Centre ID: | OSV-0008930 |
| Fieldwork ID: | MON-0045409 |

## About the designated centre

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

Avondale is a designated centre operated by St. John of God Community Services CLG. This designated centre consists of two houses which accommodate seven residents with an intellectual disability. The houses are situated in an area in Dublin that is near to local shops, public transport, the church and chemist and local amenities such as walks, pubs, restaurants, cinema and swimming. The centre provides a service to residents 24 hours a day and seven days a week. Residents in this centre require low to medium supports which is determined and supported by their personal plans. One house provides accommodation for two residents. On the ground floor there is a resident's bedroom, sitting room, kitchen, laundry areas, an accessible shower facility and toilet. Upstairs there is a resident's bedroom, a sitting room, dining room and shower facilities. There is a staff sleepover room upstairs and staff office downstairs. The other house provides accommodation for 5 residents. On the ground floor there is resident's bedroom, staff sleepover room, kitchen and living room as well as a conservatory sitting room and toilet. On the first floor there are four bedrooms, one with an en-suite and a toilet and shower facility. The person in charge of the designated centre is also responsible for two other centres. They are supported in their role by a social care leader as well as a staff team of social care workers and a staff nurse.

**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 |
|---|---|---|---|
| Wednesday 27 August 2025 | 09:30hrs to 18:00hrs | Jacqueline Joynt | Lead |

## What residents told us and what inspectors observed

This short-noticed announced inspection took place over the course of one day and was to monitor the designated centre's level of compliance with S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations).

This new designated centre was registered in April 2025. The centre consists of two houses with five residents living in one house and two residents living in the other house. The houses had previously been part of two other designated centres however, in 2024 the provider reconfigured the make up of a number of designated centres to support improved governance and management structures.

On the day of the inspection only one house was visited by the inspector. The other house was undergoing refurbishment works and the five residents had temporary relocated to other designated centre's run by the provider. The residents had been consulted about transitioning to alternative accommodation and were all provided with accessible formats of individualised transition plans. In addition, all residents were supported to visit the alternative accommodations in advance of moving into them. On review of some of the documented discussions with residents, the inspector saw that residents were happy to move to their new locations and were happy with who they were going to temporary live with.

In the house that the inspector visited, there were two resident living there. Observations alongside a review of documentation and conversations with residents, staff members, and both the person in charge and person participating in management were used to inform judgments on the quality and safety of the care and support provided to residents in the centre. Most of the information in this report relays to residents living in this house however, where it relays to the other residents, this is clearly noted.

There were compatibility issues in the centre which had been ongoing for a long time. Over the past couple of years, a number of measures had been put in place that had significantly reduced the risk of safeguarding incidents, including reducing the number of residents living in the house, changing the layout of the premises, positive behaviour supports, one to one staffing and increasing day service facilities, but to mention a few. Further measures, were planned including a resident moving to a new apartment, that would better meet their needs.

Overall, the inspector found that the provider and person in charge were endeavouring to ensure that residents in this centre were supported to enjoy a good quality life. The residents' well-being and welfare was maintained by a good standard of evidence-based care and support. However, there were some improvements needed to the areas of staff training, restrictive practices, admissions documentation, risk and protection and these are addressed further in the next two

sections of the report.

Throughout the day, the inspector observed that residents appeared relaxed and happy in the company of staff and that staff were respectful towards residents through positive and caring interactions. On occasion, the inspector observed management and staff using Lámh signs to communicate with one of the residents.

The inspector was provided the opportunity to speak with both residents. Due to the communication needs of the residents, staff supported these engagements. One resident had just returned from the hospital the night before but was happy to meet with the inspector on the morning of their arrival. They greeted the inspector and appeared happy to engage with them. Due to the medical and mobility needs of the resident their bedroom had been moved downstairs to a room that was previously a dining area. To support the resident's needs the provider had submitted an application to vary to temporary change to the layout of the room. The room was able to accommodate all the resident's medical equipment as well as their high-low bed and other items that were needed to support their health and welfare.

In an attempt to lessen compatibility issues in the house, the overall layout of the house meant that for the most part the two residents lived in separate parts of the house. For example, one resident was provided a sitting room upstairs including a dining room that included a kettle, coffee machine, toaster, microwave and fridge. Their bedroom was upstairs as well as an newly converted shower facility. Downstairs the other resident had their own bedroom, a sitting room, an accessible shower facility and kitchen and dining areas. In general, the residents kept to their own areas in the house, however, once supervised by staff, all areas of the house were available to both residents.

On walking around the premises the inspector observed that each area of the house was personal to the residents and were laid out in line with their likes and preferences. One resident enjoyed the sea-side and was supported to design their upstairs dining area with a sea-side theme when choosing colours, pictures and soft furnishings for the room.

In the afternoon, the inspector met with another resident in their upstairs bedroom. The resident enjoyed routine in their life, which the person in charge and staff facilitated. The resident had returned from their day service and were getting ready to spend some time in their upstairs sitting room and after that have their dinner in a local eatery. The resident talked to the inspector about visiting their family home at the weekend. They seemed excited about the visit. They also talked to the inspector about the restaurant they were going to and what they were going to eat there. The resident seemed relaxed and happy in their environment and with the staff member who was supporting them.

Both residents were supported to engage in their community in a way that was meaningful to them and supported their interests. One resident participated in a day service five days a week, which had been increased from three days a week. This increase also supported the resident in line with their behaviour support plan. The other resident participated in a day service three days of the week. On one of the

days they were supported by a volunteer to go to their local gym and on their free day, they prepared for their weekend visit to their family home.

The inspector found that there were good arrangements in place to support residents to communicate their wishes and make decisions about the care they received as well as raising any issues they may of had. For example, residents attended house meetings (on an individual basis), where meaningful conversations and discussions took place; Some of the matters discussed at the meetings included menu plans, community activities, appointments, goal progress, safeguarding and how to make a complaint.

Residents were also provided with key working sessions where they could discuss matters that were important to them including the progress and achievement of their personal goals. The inspector saw a number of photographs in residents personal plans of them achieving their 2025 goals as well had the goals they had set for the rest of the year.

Some of the activities residents enjoyed, which supported their personal development as well as special interests, included, going away on overnight hotel breaks, arts and crafts, going to the beautician, head massages, independent skills for moving to their new apartment, household tasks such as putting laundry into the washing machine and cooking classes, but to mention a few.

For the most part, the inspector found that residents were supported to communicate in line with their assessed needs. There were a lot of easy-to-read posters and information available to residents. Communication aids such as choice boards, visual rosters and 'first and then' boards were available to residents to support their communication and where appropriate, to support them manage their behaviours. On review of residents' personal plans, the inspector saw that where residents were referred to health professionals, the residents had received easy-to-read letters from the professionals informing about their appointment, when it would happen and what it would entail.

Staff facilitated a supportive environment which enabled residents to feel safe and protected from abuse. The inspector found that staff treated residents with respect and that personal care practices regarded residents' privacy and dignity. The inspector observed signs on residents' bedroom doors that said 'knock before entering'. Residents were also provided with person care support plans that was mindful about their personal space and dignity.

In summary, the inspector found that each resident’s well-being and welfare was maintained to a good standard and that there was a strong and visible person-centred culture within the designated centre. The inspector found that there were systems in place that were endeavouring to ensure residents were safe. It was evident that the person in charge, staff and the local management team were striving to ensure that residents lived in a supportive and caring environment where they were empowered to have control over and make choices in relation to their day-to-day lives. There were future plans in place to support residents live in a home where they were free to move around at will and promote their safety and

independence.

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 centre.

## Capacity and capability

The purpose of this inspection was to monitor the levels of compliance with the regulations and standards for this new designated centre. 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.

The inspection found that overall, residents were in receipt of a good quality and safe service, with good local governance and management supports in place. There was good levels of compliance found on the inspection however, some improvements were needed to staff training, restrictive practices, admissions, risk management and protection.

The centre had a clearly defined management structure in place which was led by a capable person in charge. The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs. They were also aware of their legal remit to S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

There was a statement of purpose in place in the centre which had been recently reviewed. However, some improvements were needed to ensure that the statement along with the associated floor plans, accurately reflected the current layout of one of the houses in the designated centre.

Admissions into the centre were considered and referred to in the centre's statement of purpose. The provider had policies and procedures in place related to admissions of residents in to the centre as well as transfers and discharge. Residents were provided with contracts of care as part of their admission into the designated centre. However, some improvements were needed to ensure all contracts of care accurately reflected the designated centre the residents were now supported by. In addition, where residents temporarily transitioned to alternative accommodation, some improvement was needed to the documentation, so that it clearly demonstrated a planned and safe move for residents.

The inspector found that the provider and person in charge had ensured that governance systems in place were effective through the auditing and monitoring of its performance. There was a quality enhancement plan (QEP) in place that

monitored the progress of actions needed to ensure the ongoing quality of care and support of residents. The person in charge was also responsible for a schedule of local audits carried over the year. In addition, peer to peer audits that, reviewed compliance levels with the regulations, were being completed. These audits assisted the person in charge ensure that the operational management and administration of centre resulted in safe and effective service delivery.

There were clear lines of accountability at individual, team and organisational level so that all staff working in the centre were aware of their responsibilities and who they were accountable to. There was a staff roster in place and it was maintained appropriately. There were two staff vacancies in the centre at the time of the inspection and these were primarily covered by the same agency and relief staff who were familiar to the residents.

There was a training schedule in place for staff working in the centre and this was regularly reviewed by the person in charge. For the most part, staff were provided with the necessary skills and training to the delivery quality, safe and effective service. However, some improvements were needed to ensure all staff were provided training that met residents' assessed needs and in particular, that it was up-to-date and where appropriate, delivered on a frequent basis.

Incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. There was appropriate information governance arrangements in place to ensure that the designated centre complied with all notification requirements.

## Regulation 14: Persons in charge

The person in charge was familiar with residents' needs and was endeavouring to ensure that they were met in practice. There was evidence to demonstrate that the person charge was competent, with appropriate qualification and skills and sufficient practice and management experience to oversee the residential service and meet its stated purpose, aims and objectives.

The person in charge was also responsible for the management of two other designated centres. The local monitoring systems and structures in place included the support of a social care leader in each of the centres the person in charge was responsible for. This was to ensure effective governance, operational management and administration of the designated centres concerned.

As a result the person in charge was more involved in the day to day running of this centre and one other. In particular, focusing on staffing arrangements and the daily care and support needs of residents. It meant that their time allotted to local governance, operational management and administration of the centre was limited at times.

The inspector was informed that a new social care leader would commence in early

September 2025 and due to the current numbers of units in this centre, would also support the person in charge with the other designated centre also.

Judgment: Compliant

## Regulation 15: Staffing

The person in charge was endeavouring to ensure continuity of care despite there being two staff vacancies in the centre; one social care leader, one social care worker. On the day of the inspection, the inspector was informed that a new staff member, social care leader, was due to commence working in the centre on 8th of September.

Staff members from the provider's relief staff team, as well as agency staff, were employed to work in the centre to cover the staffing roster gaps. On review of the roster from June to August 2025, the inspector saw that the same two agency staff and same four relief staff were employed on a regular basis. These staff were familiar to the residents and aware of their support needs. The inspector was also informed that these staff had worked in the centre for a long period.

Overall, the planned and actual roster was maintained appropriately. The roster clearly demonstrated when the person in charge worked on-site in this centre.

In addition to the planned and actual staff rosters, residents were provided with visual rosters that included photographs of the staff working each day. These were in place as a form of information for residents but also to ease any anxieties that residents may have about what staff were supporting them on the day.

On observing staff support residents during the day, the inspector saw that engagements were kind and caring and residents seemed comfortable in the company of staff members.

Judgment: Compliant

## Regulation 16: Training and staff development

All staff were in receipt of supervision and support relevant to their roles from the person in charge. Dates had been scheduled for the next set of supervision meetings with the new social care leader due to commence in September 2025.

On review of the staff training records, the inspector saw that staff had completed a range of training courses to ensure they had the appropriate levels of knowledge and skills to best support the residents. These included training in mandatory areas such as fire safety, manual handling, safe administration of medication and

safeguarding of vulnerable adults.

In addition, training was provided in areas such as human rights, feeding, eating, drinking and swallowing (FEDS), infection prevention and control, positive behaviour supports, and crisis prevention and intervention.

However, some improvements were needed, for example:

Three staff were due to complete positive behaviour support training. The training records demonstrated that one staff member had completed their positive behaviour support training in 2019. The inspector was informed that positive behaviour support training was a one off training and that there was no timeline for refresher training in this area. Overall, the inspector found, that considering the assessed needs of residents, a review of the frequency of providing positive behaviour supports training was needed.

In addition, one staff had not completed First aid or Triple C communication training.

Furthermore, not all staff were provided training to support them communicate with the resident in one of the ways the resident understood. For example, on review of a resident's communication support plan as well as their behaviour support plan, the inspector saw that staff were to support the resident use Lámh (sign language) in conjunction with two other types of communication methods.

The inspector was informed by management that in May 2024 all staff were trained in Lámh however, with the change in staff members since that time, two staff did not have this training. In addition, on the day of the inspection, there was no evidence to demonstrate that the regular agency and relief staff had been provided in Lámh training. This meant that there was potentially eight staff supporting a resident who did not have all the skills required to meet their communication needs.

Judgment: Substantially compliant

## Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents in the designated centre. The directory viewed (for the house visited) had elements of the information specified in paragraph three of Schedule 3 of the regulations.

Judgment: Compliant

## Regulation 23: Governance and management

The governance and management systems in place were found to operate to a good standard in this centre. There was a clearly defined management structure that identified the lines of authority and accountability.

While there were current vacancies in the management structure, the inspector was informed that there had been additional meetings and engagement between the person participating in management and the person in charge. These meetings supported the person in charge in the role towards the effective governance and administration of the centre.

As the centre was registered in April 2025, there was no requirement for an annual review or six monthly unannounced visit to be completed at this stage. However, there were other monitoring and overnight arrangements in place that ensured the quality of support and care of residents. For example, the provider had implemented a quality enhancement plan, (QEP), which was regularly reviewed and updated by local and senior management. There was a schedule of peer to peer audits in place. The audits ensured good oversight and shared learning between the three designated centres the person in charge was responsible for. Some of the recent audits focused on, protection, rights, complaints, fire safety, general welfare and residents personal plans.

In addition, there were checks in place for fire safety systems and daily and nightly cleaning duties. There was a handover book and daily duties book also in place that included oversight by the person in charge. The latter two ensured that staff were accountable and had specific roles and responsibilities in relation to the day-to-day running of the centre. Furthermore the person in charge had recently carried out a medication audit.

Staff team meetings were taking place regularly and provided staff with an opportunity for reflection and shared learning. On review of the minutes of the last two meetings the inspector saw that topics such as residents support needs, safeguarding, accidents and incidents, roster planning, infection prevention and control measures, quality enhancement plan, health and safety were discussed.

Judgment: Compliant

## Regulation 24: Admissions and contract for the provision of services

There were contracts of care in place for the two residents. On review of the contracts of care, the inspector found that they were written in plain language and included clear terms and conditions.

However, the inspector saw that the contracts were completed in August 2024 and had not been reviewed since the residents' home changed to this new designated centre. The document referred to the previous designated centre. This meant that the residents' contract of care was not fully accurate or consistent with the

provider's statement of purpose for the centre.

In relation to the five residents who had transitioned into alternative accommodation while their house was being refurbished, improvements were needed to ensure all planning and assessments were appropriately documented. For example, management, informed the inspector that there had been a number of planning meetings with the appropriate stakeholders about residents moving into other designated centre. The inspector was advised that residents' safety and protection was taken into account and discussed at length at these meetings. However, no written compatibility assessments or risk assessments, to demonstrated the protection measures discussed, had been completed after the meetings.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The statement of purpose did not accurately reflect the current layout of one of the houses in the designated centre.

On the day of the inspection, the person participating in management updated the document so that it included written details of each room and its function as well as the room sizes.

A review and update of the centre's floor plans was also required to ensure it was in line with the updated statement of purpose as well as the regulatory requirement of submitting floor plans that clearly showed room function and sizes.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

There were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The person in charge had ensured that all adverse incidents and accidents in the designated centre, required to be notified to the Chief Inspector of social services, had been notified and were within the required timeframes as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

The inspector found that incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. On review of team meeting minutes and through speaking with the person in

charge, the inspector found that where there had been incidents of concern, the incident and learning from the incident, had been discussed at staff team meetings.

Judgment: Compliant

## Regulation 34: Complaints procedure

The registered provider had established an effective complaints procedure underpinned by a comprehensive policy. The complaints procedure was available in an easy-to-read format and accessible to residents.

On the day of the inspection, a copy of the compliant procedure and advocacy information, including easy-to-read format was put up in a communal area of the house which meant it was clear for residents, family and representative to see.

From speaking with management and a review of records, the inspector saw that residents were supported to know how to make a complaint. This was primarily through discussion at house meetings and keyworking sessions which promoted awareness and understanding of the complaints' procedures.

The inspector was informed on the day, that there were no open complaints or recently closed complaints in the centre.

Judgment: Compliant

## Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre.

The inspector found that the resident's well-being and welfare was maintained by a good standard of evidence-based care and support. It was evident that the person in charge and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. However, to ensure positive outcomes for residents at all times, some improvements were needed to the following areas; positive behaviour supports, risk management and protection.

Only one of the two premises was visited on this inspection. The house was observed to be clean and tidy and presented a comfortable and homely environment for residents. Residents were provided with their own bedrooms, which were decorated in line with their taste and preferences. The layout of the house meant that each resident were provided with their own sitting and dining room.

In the second premises, residents had been supported, in a person-centred way, to transition to other designated centres. This was on a temporary basis while their home underwent works that would make it more accessible and better meet their changing needs. The residents had been consulted with throughout the process and they were supported to visit their new location in advance of the move.

An assessment of need was completed for each resident and was reviewed in consultation with the resident and where appropriate their family. Assessments also included multi-disciplinary input. In line with residents communications needs, they were provided with an accessible version of their personal plan.

Residents that required support with their behaviour were provided support plans for this area. There were minimum restrictive practices used in this centre and for the most part they were in line with best practice. However, some improvements were needed to ensure that rights restrictions were also processed in line with best practice.

There was an up-to-date safeguarding policy in the centre and it was made available for staff to review. Staff working in the centre completed training to support them in preventing, detecting, and responding to safeguarding concerns. Where there were safeguarding concerns, the person in charge had ensured that there were safeguarding plans in place. However, improvements were needed to ensure that safeguarding plans were available to all staff for all of the time and that the measures within them were effective.

The provider had ensured that the risk management policy met the requirements as set out in the regulations. There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre. For the most part, all potential risks included a written assessment with appropriate measures.

There were infection, prevention and control measures and arrangements to protect residents from the risk of infection. From a review of documentation, from speaking with management and from observations in the centre, the inspector found that infection, prevention and control measures were effective and efficiently managed to ensure the safety of residents.

## Regulation 10: Communication

The two residents living in the centre presented with different communication support needs.

In documentation related to residents, there was an emphasis on how best to support residents to understand information. For example, in residents personal plans and where appropriate, in positive behaviour support plans.

The person in charge was striving to ensure that residents could receive information in a way that they could understand and was in line with their assessed support

needs. For example, information for residents was provided in easy-to-read format, pictures and photographs. There were photographic format staff rosters, easy-to-read and photographic format of goals achieved by residents in their personal plans, easy-to read household meeting agenda and minutes, pictures and photographs were used for residents menus choices and activity choices. Furthermore, correspondence from health professionals was provided in easy-to-ready format .

Residents had been provided a communication assessment using the Triple C format and the outcome of the assessments then informed the support plan required for each resident. The plan guided staff in how to best understand and communicate with residents in line with the outcome of the assessments' symbolic established level. In addition, staff were provided training in the Triple C format.

On speaking with staff members it was evident that they were aware of the communication supports that residents required and for the most part were knowledgeable in all ways of communicating with residents. However, some improvements were needed to ensure all staff were trained in Lámh, a sign language that one resident's communication and behaviour support plan directed staff to use in conjunction with 'first and then' system and choice boards. This has been addressed under Regulation 16.

Judgment: Compliant

## Regulation 17: Premises

The physical environment of the house was clean and tidy. For the most part, the design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable and homely environment. This enabled the promotion of independence, recreation and leisure. For example, to support a resident's mobility needs, an accessible path had been put in place to the side and front of house, this also assisted a safe evacuation of the resident in case of fire. In addition, a bathroom upstairs had been converted into a shower room for better ease of access for residents.

Furthermore, an application to vary the layout of the ground floor on a temporary basis had been submitted by the provider in October 2024. This was to accommodate the provision of a downstairs bedroom for one resident in line with their changing medical, health and mobility needs and to support them convalesce in their own home. The change in layout as well as other mobility requirements in the house had been assessed and recommended by appropriate health professionals.

The layout of the house also meant that compatibility issues between the two residents living in the house was at a minimum however, resulted in a level of restrictive practice in use. One resident primarily lived in the ground floor where there was a toilet and shower facility, a sitting room, a kitchen and laundry room as

well as their bedroom. The other resident primarily used the area upstairs which included a dining room that consisted of a table and chair, large couch, a fridge, coffee machine, kettle, toaster and microwave. There was also a sitting room and shower facility upstairs. This arrangement limited the independent use of cooking and laundry facilities for one resident.

The residents' living environment provided appropriate stimulation and opportunity for the residents to rest and relax. Each resident was provided with their own sitting room that included a television, couches, tables and sufficient space for residents to read their magazines, play table top game and relax and listen to music or watch television as well as spending time with visitors.

Residents expressed themselves through their personalised living spaces, such as their bedrooms and their sitting rooms. The residents were consulted in the décor of their rooms which included family photographs, paintings and memorabilia that were of interest to them.

Judgment: Compliant

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

Five residents who were living in one of the houses in the designated centre were support to temporarily transition to other designated centres while their home underwent refurbishment works as well as an extension.

The provider and person in charge had systems to ensure appropriate planning, supports and safe transfers were in place for residents when they transferred to other locations.

Frequent planning meetings between managers and key stakeholders supported the smooth and safe transition of residents to their new temporary homes.

Overall, the inspector found that the temporary change in location for residents was not disrupting or impacting negatively on key events in their lives. The residents were included and consulted about the temporary move to other designated centres and this was reflected in their transition plan. The voice of each resident was captured by the service using communication that was tailored to the individual resident.

In advance of moving to other residential centres residents were provided with an individualised easy-to-read format of their transition plan. The plans clearly described to each resident pertinent information about their move. The inspector reviewed a sample of four plans and saw that they provided an explanation as to why they were required to move. For example, building works required to make their home more accessible for them. The plans also included pictures of the designated centre they were temporally moving to, who lived there and what staff were supporting with the move. In addition, the transition plans included a list of

personal items residents were bringing to their new home. For example, one resident's personal possessions list including bringing their television, art desk and chair. Residents were also informed about member who would be working with them, safety information such as the fires drill and the date on when they were moving and how they were going to get there. Each plan demonstrated that residents had been supported to understand their transition in a communication format that was in line with their assessed needs.

Where residents attended community activities such as day service, activity clubs or other activities that were of interest to them, they were accommodated to continue to attend them. Overall, this had been considered at the early planning stages of the move.

Judgment: Compliant

## Regulation 26: Risk management procedures

The designated centre's risk management policy had ensured that the policy met the requirements as set out in the regulations.

For the most part, where there were identified risks in the centre, the person in charge ensured appropriate control measures were in place to reduce or mitigate any potential risks.

For example, there were a range of risk assessments with appropriate control measures, that were specific to residents' individual health, safety and personal support needs. There were also centre-related risk assessments completed with appropriate control measures in place.

However, some improvements were needed. Two examples are listed below;

The inspector saw that a number of risk assessments, reviewed 26 August 2025, had not accurately reflected the name of the current designated centre.

There was no appropriate risk assessment for the compatibility issues that had led to safeguarding incidents in the house. While a number of control measures had been put in place to reduce the risk, such as changing the layout of the house, decreasing resident numbers, providing positive behaviour supports and seeking alternative living for one resident, but to mention a few, an associated risk assessment was not in place.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

The inspector found that the infection prevention and control measures were effective and efficiently managed to ensure the safety of residents living in the designated centre.

The inspector observed the house to be clean and tidy demonstrating a good level of adherence to the cleaning schedules in place. Both the handover book and daily duties folder included information on cleaning schedules and duties. In addition, there were daily check lists for fridge and freezer temperatures.

Policies and procedures and guidelines in place in the centre in relation to infection prevention and control clearly guided staff in preventing and minimising the occurrence of healthcare-associated infections. For example, there were cleaning procedures and guidance in place for staff to support them in effectively carrying out cleaning duties. Residents mobility aids and supports as well as medical equipment were included on cleaning lists. Overall, the inspector observed that staff were engaging in safe practices related to reducing the risks associated with spread of infectious decease when delivering care and support to the residents.

All staff had completed specific training in relation to infection, prevention and control which ensured they were provided with the appropriate skills and knowledge in keeping residents safe and free from spread of infection.

The designated centre's contingency plan, in the case of an infectious decease outbreak, had been reviewed and updated by the person in charge on the 15 July 2025.

Overall, the house was observed to be in good upkeep and repair which ensured that all areas could be effectively cleaned (in terms of infection, prevention and control). On the day of the inspection, the inspector observed that one of the shower trays had no grout or silicon on one side fo the tray. As a result, there was a build up of dark grime in the gap which was hard to clean. When this was pointed out to management, they called the organisation's maintenance team and a repair date for the following week was scheduled.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

The inspector reviewed the residents' assessments of needs and found that they were comprehensive and up to date. The 'All about Me' assessments were informed by the residents, their representatives and multidisciplinary professionals as appropriate. The assessments informed comprehensive care plans which were written in a person-centred manner and detailed residents' preferences and needs with regard to their care and support.

On reviewing the two residents' personal plans overall, the inspector found that the

plans demonstrated that each resident was facilitated to exercise choice across a range of daily activities and to have their choices and decisions respected. Personal plans were regularly reviewed and residents, and where appropriate their family members and representatives, were consulted in the planning and review process of their personal plans.

One resident's plan showed that their 'circle of support' meeting had taken place in June 2025. The residents was at the centre of the meeting and their family, key working staff and management attended the meeting. The resident's communication needs were considered at the meeting. The meeting included an array of photographs of the resident's achieved goals as well as the goals they would like to work towards in the future. In addition to this, residents were supported to meet with their key worker on a regular basis to review the progress of their goals. Outcomes of the meetings were recorded in each of the resident's personal plan.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The provider and person in charge promoted a positive approach in responding to behaviours that challenge and overall ensured evidence-based specialist and therapeutic interventions were implemented.

The inspector found that there were arrangements in place to provide positive behaviour supports to residents with an assessed need in this area. The inspector saw evidence that there were clear, correct and positive communications which helped residents understand their own behaviour and how to behave in a manner that respects the rights of others and supports their development.

Overall, the inspector found that the provider and person in charge were striving to promote a restraint free environment. The inspector saw there where restrictive procedures were in use, they were based on best practice and centre policies. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals involved in the assessment and interventions with the individual.

However, some improvements were needed; On the day of the inspection, a resident's limited access to the downstairs kitchen and laundry room, had not been identified as a rights restriction. While the restriction was supporting the residents' safety, as it had not been followed up in line with best practice, it meant that the provider could not be assured that the restriction was the least restrictive for the shortest amount of time.

For example, as part of a safeguarding measure, residents were supported to have separate living areas in their home. One resident was provided with their own dining area and sitting room upstairs. While they could avail of the downstairs kitchen and laundry area, staff supervision was required during these times to mitigate the risk

of a safeguarding incident. This meant that the resident was restricted from entering these areas independently or freely by themselves.

Judgment: Substantially compliant

## Regulation 8: Protection

The provider and person in charge had ensured that safeguarding concerns were documented, investigated and reported to relevant authorities in line with legislation. On a sample of safeguarding incidents, the inspector found that the person in charge had ensured they had been followed up appropriately and in line with policy. Incidents had been screened, investigated and notifications submitted to the appropriate services. In addition, there was a safeguarding vulnerable people governance monitoring tool in place. The tool was in place to ensure that all required forms had been completed, safeguarding plans were in place and actions completed and that there was a review of the process. However, on review of the tool, the inspector found that some improvements were needed to ensure the effectiveness of the tool at all times.

There were two active safeguarding concerns in the designated centre. One related to compatibility issues between two residents and the other related to allegations of physical harm.

The later concern was primarily related to the behaviours of one resident; on a regular basis, the resident vocalised one sentence allegations of physical harm to them. At the time of the allegations, it was observed that there was no risk, concern or physical harm caused to the resident. Post screening, incidents were closed off and no grounds for concern were noted.

There were a number of safeguarding measures in place to try and identify what was behind the allegations. One of the measures included the resident meeting with a speech and language therapist on a 'regular and ongoing basis'. On review of the resident's appointments the inspector saw that the resident was supported to attend a therapist in February and again in May 2025. However, despite an increase in safeguarding incidents reported in June, July and August, there had been no further meetings since May.

In relation to the concern regarding compatibly issues, the inspector found that, despite a low risk of related safeguarding incidents occurring, measures that guided staff in mitigating the risk were not readily available to them. For example, on the day the inspection, the resident’s safeguarding plan was not included in their personal plan or in the staff hand-over folder where these types of plans were normally filed in this centre.

This meant that there was a risk to the consistency of approach by staff, including relief and agency, should a safeguarding incident occur.

Judgment: Substantially 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 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 24: Admissions and contract for the provision of services | Substantially compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 25: Temporary absence, transition and discharge of residents | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Avondale OSV-0008930

## Inspection ID: MON-0045409

## Date of inspection: 27/08/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br><br>Positive behaviour support training has been scheduled for 3 staff and will be completed by 31.01.2026.<br>The frequency of positive behaviour support training for this location will be agreed and implemented as part of the overall Centre training programme.<br>One staff member has been scheduled for First aid and Triple C and this will be completed by 31.12.2025.<br>One staff member will attend a one day training session to become the Lamh champion for the location and an additional location specific Lámh session will be scheduled with the Speech and Language Department. This will be completed by 31.12.2025. | |
| Regulation 24: Admissions and contract for the provision of services | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:<br><br>The Contracts of Care will be reviewed to ensure they accurately reflect the new Designated Centre name and in turn, are consistent with the statement of purpose for the centre. This will be completed by 31.12.2025.<br><br>Compatibility assessments/risk assessment will be completed and documented to demonstrate the protective measures discussed and put in place ahead of residents transitioning to an alternative home as part of another Designated Centre. This will be completed by 30.10.2025. | |
| Regulation 3: Statement of purpose | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 3: Statement of purpose: | |

A review and update of the centre's floor plans has been completed, and they are now in line with the updated statement of purpose. An application to vary will be submitted with the revised floor plans. This will be completed by 10.10.2025.

| Regulation 26: Risk management procedures | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

All risk assessments will be reviewed to ensure they accurately relefect the name of the Designated Centre. Where the risk management system cannot be updated, an interim arrangement will be put in place to clearly document the Centre name on each risk assessment. This will be completed by 31.11.2025.
A risk assessment has been completed for the compatablity issues within the house. This includes the control measures that have been put in place and the actions planned. This was completed by 19.09.2025.

| Regulation 7: Positive behavioural support | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The residents limited access to the downstairs kitchen and laundry area has been referred to the services Equality and Human Rights Committee in line with the Enabling a Restraint Free Environment Policy. This was completed 22.09.2025. Due process will be followed along with the recommendations to ensure the restriction is least restrictive for the shortest period of time.

| Regulation 8: Protection | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 8: Protection:

The Safeguarding vulnerable people governance monitoring tool has been reviewed and updated to accurately reflect the status of each action. All relevant information relating to each action has also been included. This was completed 31.10.2025.

A system has been put in place to ensure the resident’s safeguarding plan is available to staff at all times. Staff have been informed of this system. This was completed by 19.09.2025.

## 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 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Substantially Compliant | Yellow | 31/01/2026 |
| Regulation 24(1)(b) | The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers. | Substantially Compliant | Yellow | 31/12/2025 |
| Regulation 24(4)(b) | The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement | Substantially Compliant | Yellow | 31/12/2025 |

| | | | | |
|---|---|---|---|---|
| | of purpose. | | | |
| 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. | Substantially Compliant | Yellow | 30/11/2025 |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 10/10/2025 |
| Regulation 07(5)(c) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used. | Substantially Compliant | Yellow | 22/09/2025 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 19/09/2025 |