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:	SVC - BW
Name of provider:	Avista CLG
Address of centre:	Dublin 7
Type of inspection:	Announced
Date of inspection:	15 April 2026
Centre ID:	OSV-0004028
Fieldwork ID:	MON-0041265

About the designated centre

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

The designated centre is made up of one unit and is based on a campus setting in North Dublin. It provides 24 hour residential supports for up to four residents with complex support needs. The centre is comprised of two areas one of which accommodates one resident. It contains a kitchen and dining room, a small sitting room, a bathroom and a bedroom. The second area of the centre accommodates three residents and contains a staff office, three resident bedrooms, a kitchen and dining room, a laundry room, a sitting room, and a bathroom. Both areas of the centre share an outdoor garden space. The staff team employed in the centre are made up of a person in charge, a clinical nurse manager, social care workers, staff nurses, and carers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 April 2026	10:30hrs to 17:30hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

From what the inspector of social services observed, there was evidence that the residents living in the centre received quality care and support. However, improvements were required so as to ensure that each residents had appropriate supports to develop and maintain relationships and links with the wider community in accordance with their wishes and assessed needs. Some improvements were also identified as required in relation to maintenance of the premises, arrangements for recording of activities that the residents engaged in and for identifying and progressing specific and meaningful goals for residents. Further to the last inspection, arrangements had been put in place to facilitate residents to have each of their meals now prepared and cooked in the centre.

The centre is situated on a campus-based setting, with 10 other residential bungalows, all of which are operated by the provider. The centre is located in close proximity to local amenities, including, shops, restaurants, cinema, a swimming pool, public parks and public transport links.

The centre is a bungalow and comprises of two separate areas. The central area has a kitchen come dining room, a sitting room area, three resident bedrooms, and an adapted bathroom with shower and bath facilities. There is also an adjoining self contained apartment which comprised of an open-plan living and dining space with a kitchenette, a resident's bedroom and a shower room with toilet and wash hand basin. This area had a minimalistic feel as per the resident's preference. The resident's bedroom had recently been refurbished with new flooring and a new bed. Each of the residents had their own bedroom which had been personalised to their own taste and choice. Pictures of residents' family members were observed in a number of bedrooms and one of the residents had a framed poster of their favourite football club and of the 'star wars' movie. Art work completed by some of the residents was framed and on display in areas. There was a secure, private and accessible garden for residents use. This garden had been refurbished in 2024 with artificial grass. Residents could also access a number of communal gardens and exercise area within the campus and a sensory garden with staff support. Laundry facilities were available in an external utility room.

The centre is registered to accommodate up to four adult residents and there were no vacancies at the time of inspection. Three of the residents were present on the day of inspection. The fourth resident was attending their day service followed by a planned overnight visit to their family home. The residents present, were unable or reluctant to tell the inspector their views of the service but they appeared in good form and comfortable in the company of staff and their peers. It was noted that a low arousal approach was being used with staff observed to respond appropriately to residents who communicated with some words, gestures and sounds. One of the residents attended their day service during the early part of the day while the other two residents were in the centre. Calming music was heard playing while one of the

residents enjoyed a short nap in the afternoon. One of the residents was observed enjoying a healthy lunch which they had engaged with staff in preparing. Another resident was observed walking in the centres garden at various times of the day.

There were long term plans to de-congregate the centre. A defined time-line for the de-congregation of the entire centre had not yet been confirmed but transition plans for two of the residents to move to a new home within the community were at an advanced stage.

The two identified residents for transition were living together in the main area of the centre. The service manager reported that a new property had been secured and was in the final stages of being furnished. It was proposed that the provider would be submitting an application to register the new house as a designated centre in the coming period. A number of familiar staff had been identified to transition with the residents to their new home. Some visits with the identified residents had been completed to use facilities in the area and to familiarise the residents with the area. This included visits to a local pub and grocery shopping in the area.

A discovery process had been completed with the two residents and their families. This assessed the individual residents' needs and preferences in relation to their future life plans as they transition to live in their own home within the community. The provider had put in place a 'transforming lives' lead who was responsible for coordinating the de-congregation process. A number of management and staff had completed enhanced quality 'good lives' training for de-congregation.

Each of the four residents had been living in the centre for an extended period. The three residents living in the main part of the house were reported to be compatible with each other. However, the behaviours of all four residents could on occasions be difficult for staff to manage in a group-living environment. As identified on the last inspection, on occasions the space and layout in the centre negatively impacted on staffs' ability to support residents to manage behaviours. Overall, incidents appeared to be well managed and residents were provided with appropriate support. There had been two safeguarding peer-to-peer incident in the preceding 12 month period.

Staff were observed to interact with the residents in a caring and respectful manner. Each of the residents had assigned key workers. The inspector noted that residents' needs and preferences were well known to staff and the person in charge. A number of the residents had limited speech but were observed to be supported by staff to communicate their feelings and wishes. It was reported by the service manager that there were no plans to admit any new residents to the centre following the transition and discharge of the two identified residents from the centre. It was considered that the additional space and individualised living arrangements that this would afford the remaining two residents would greatly enhance their quality of life.

There was evidence that residents and their representatives were consulted and communicated with, about decisions regarding their care and the running of the centre. Each of the residents had regular one-to-one meetings with their assigned key workers. Residents were supported to communicate their needs, preferences and choices at these meeting in relation to activities and meal choices. The inspector

did not have an opportunity to meet with the relatives or representatives of any of the residents but it was reported that they were happy with the care and support that the residents were receiving. The provider had consulted with residents' families as part of its annual review of the quality and safety of the service and the feedback from families was positive. Staff had completed office of the chief inspector questionnaires on behalf of residents and these indicated that they were happy with the care provided.

Residents were supported and encouraged to maintain connections with their friends and families. A number of the residents were supported to visit their family home on a regular basis and visits by friends and family to the centre were facilitated. Two of the residents went for over night stays to their family homes each week.

A number of residents were supported to engage in meaningful activities in the centre and within the local community at a level that best suited the individual. However, it was noted that engagements for some residents within their local community was limited and contrary to proposed activity plans proposed by an individuals behaviour support plan. Three of the four residents were engaged in a formal day service programme operated within the campus. Two of the residents attended the day service four days per week but the third resident only attended one day per week. Additional hours for this resident has been sought. The fourth resident was engaged in individualised activities coordinated from the centre which it was felt best met this resident's needs. Examples of other activities that a number of the residents engaged in within the centre and within the community included, walks within the campus and to local scenic areas and beaches, church visits, family home visits, cooking and baking, gardening, arts and crafts, meals out, bowling and shopping. It was noted that the activity logs for some of the residents were not being appropriately recorded. One of the residents enjoyed looking at books with staff on motor bikes and airplanes. They also enjoyed playing safety darts in the centre with staff.

The centre had limited access to a vehicle which could be used to facilitate residents to access community activities and visits to families. However, the vehicle was only generally available at weekends and after 3pm during the week. It was reported by staff that a number of the residents preferences was only to access the community during quieter times of the days, i.e. morning times during the week but that the vehicle was generally not available during these times.

In addition, not all of the staff team were licensed to drive which consequently could impact on residents being able to access their community. The centre was located in close proximity to a range of public transport links. However, it had been assessed that public transport was not a suitable means of transport for a number of the residents.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

There were suitable governance and management arrangements in place. However, a non compliance was identified in relation to Regulation 13 which had not been identified by the provider through their own audit processes. The provider had completed an annual review of the quality and safety of care for 2025, which included consultation through survey with families to attain their views of the service. Unannounced visits, to review the safety of care, on a six monthly basis as required by the regulations had been completed with the most recent being in March 2026. There were clear lines of accountability and responsibility. A schedule of audits were in place which were overseen by the person in charge.

The person in charge was on planned leave on the day of inspection but was spoken with subsequent to the inspection. The inspection was facilitated by the clinical nurse manager 1(CNM1) who had taken up the post in November 2025.

The person in charge held suitable qualifications and management experience to meet the requirements of Regulation 14. The person in charge had a sound knowledge of the assessed needs and support requirements for each of the residents and of the requirements of the regulations. They had been working within the service for an extended period. They were in a full-time position and were also responsible for one other centre located nearby on the same campus. The person in charge reported that they felt supported in their role and had regular formal and informal contact with their manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge was supported by the CNM1. The person in charge reported to a clinical nurse manager grade 3 (CNM 3) who in turn reported to the service manager. The person in charge and CNM3 held formal meetings on a regular basis.

The provider had completed an annual review of the quality and safety of the service and unannounced visits, to review the safety of care, on a six-monthly basis as required by the regulations. A number of other audits and checks had been completed. Examples of these included, infection prevention and control, health and safety, finance, incident reports, care plans and medication. There was evidence that actions were taken to address issues identified in these audits and checks. There were regular staff meetings and separately management meetings with evidence of communication of shared learning at these meetings.

A record of all incidents occurring in the centre was maintained and overall where required, these were notified to the Chief Inspector, within the time-lines required in the regulations.

Registration Regulation 5: Application for registration or renewal of registration

The purpose of the inspection was to assess the provider's application to renew the registration of the designated centre. The inspector reviewed the documentation submitted as part of the renewal application, including the statement of purpose and supporting information required under Schedule 1 of the Regulations. The inspector found that the provider had submitted a complete and accurate application for renewal of registration. The resident guide had been reviewed in January 2026.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives. The inspector reviewed the Schedule 2 information, as required by the Regulations, which the provider had submitted for the person in charge. These documents demonstrated that the person in charge had the required experience and qualifications for their role. The person in charge was in a full time position and was responsible for one other centre located adjacent to this centre. The person in charge reported in to this CNM3 who in turn reported to the service manager. In interview with the inspector, the person in charge demonstrated a good knowledge of the residents' care and support needs and oversight of the centre.

Judgment: Compliant

Regulation 15: Staffing

The staff team were found to be appropriately qualified and experienced to meet the residents' needs. The full complement of staff were in place at the time of this inspection. This provided consistency of care for the residents. A small number of regular relief staff were being used to cover staff leave. The staff team comprised of a person in charge, clinical nurse manager 1/ deputy manager, two staff nurses, a social care worker, healthcare assistants and household staff. The person in charge and deputy manager both had a nursing background. Staff were observed to be respectful, kind and caring. The majority of the staff team had been working in the centre for an extended period. This provided consistency of care for the residents.The actual and planned duty rosters were found to be maintained to a satisfactory level. There were regular staff meetings every six to eight weeks and

evidence that agreed actions from each meeting were followed up on at the next meeting.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with appropriate training to support them in their roles. There was a staff learning and development policy in place. Records showed that staff had attended all mandatory training and refresher training was scheduled for a number requiring same. A training needs analysis had been completed and there was evidence that the person in charge liaised with the provider's training coordinator. Suitable staff supervision arrangements were in place.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place, which had recently been reviewed. It was found to contain all of the information as set out in schedule 1 of the Regulations and to accurately describe the service provided. A copy of the statement of purpose was available for residents and their representatives in an easy to read format.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications of incidents were reported to the office of the Chief Inspector in line with the requirements of the regulations. There were arrangements in place to review trends of incidents and actions taken on a quarterly basis or more frequently where required.

Judgment: Compliant

Quality and safety

The residents living in the centre appeared to receive person-centred care and support which was of a good quality. However, improvements were required so as to ensure that each residents had appropriate supports to develop and maintain relationships and links with the wider community in accordance with their wishes and assessed needs. Some improvements were also identified as required in relation to maintenance of the premises, arrangements for recording of activities that the residents engaged in and for identifying and progressing specific and meaningful goals for residents.

The residents' medical needs and welfare was maintained by a good standard of evidence-based care and support. However, it was noted that specific, meaningful and measurable goals had not been identified for some residents and progress in achieving other goals were not always recorded.

There was a health action plan for each of the residents which included an assessment and planning for individual resident's physical and mental health needs. Personal support plans reflected the assessed needs of individual residents and outlined the support required in accordance with their individual health, communication and personal care needs and choices. Detailed communication passports were in place to guide staff in supporting the resident to effectively communicate. A number of the residents were engaged with the provider's speech and language therapist to support their communication.

The health and safety of the residents, visitors and staff were promoted and protected. Individual and environmental risk assessments had been completed and were subject to review. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents. This promoted opportunities for learning to improve services and prevent incidences.

Regulation 13: General welfare and development

Improvements were required so as to ensure that each residents had appropriate supports to develop and maintain relationships and links with the wider community in accordance with their wishes and assessed needs. Access to the community, off campus was limited for some residents. For one of the residents, records suggested that the resident had only accessed their local community four times in the preceding month although they had engaged in walks and activities within the campus. It was noted that a number of the residents found it difficult to access the community during noisy and busy times, which tends to be evenings and weekends. However, the centre generally only had access to a suitable vehicle for the use of staff to take the residents out at weekends and from 3pm each day. In addition a number of the staff team were unable to drive which sometimes negatively impacted on staffs ability to take residents out into the community. .

The proposed monthly activity calendar for another resident with complex needs was not being followed which was contrary to the resident's behaviour support plan. It was noted that this resident's behaviour support plan outlined a need for predictable routines, repetitive structure and that a rotation of activities needed to be offered, at well spaced intervals to manage the resident's assessed anxiety levels. An activity calendar was proposed to support the approach. However, records reviewed indicated that the proposed activities outlined in the individual calendar had not been undertaken and there was no record of an explanation for same.

It was noted that this resident had successfully accessed the community for short periods on two occasions in October 2025 which it was reported that the resident had appeared to enjoy. However, subsequent records indicated that the resident had not left the campus or experienced an activity in the community in November or December 2025. The rationale for same was not recorded. It was noted that the resident did access the community on one occasion in both January and February 2026 which was not in line with the proposed activity plan in place.

Judgment: Not compliant

Regulation 17: Premises

The centre was comfortable and clean. However, some worn paint was noted on woodwork in some areas. The flooring in one of the resident bedrooms and in the staff office was worn in areas. The two sofas in the sitting room in the main part of the house had broken surfaces. A larger fridge had been ordered for the main kitchen as there was only a small under counter fridge in place with limited storage. It was noted that the overall living space, particularly corridors was limited for the four residents living there but all egress routes were maintained clear. The resident living in the self contained apartment had a preference to have baths versus showers. However, a bath was not available in their own living area so they were facilitated to use the bath in the main part of the house.

It was considered that the planned transition and discharge of the identified two residents from the centre in the coming period would greatly enhance the living space for the remaining two residents living in the centre. It was proposed that the layout of the centre would be reconfigured following the transition of the two residents to include the provision of a bath area for each remaining resident. A number of rooms had a minimalistic feel as per the residents reported preferences. Each of the residents had their own bedroom which had been personalised to their own taste and choice. The flooring and bed in one of the residents bedrooms had recently been replace.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

From observations and review of records, it was noted that residents were provided with a varied and nutritious diet. At the time of the last inspection, the main meal of the day was being prepared in a centralised kitchen located on another campus-based setting operated by the provider with the meals then transferred heated to the centre. The chief inspector considered that these practices were institutionalised and limited residents' involvement in buying, preparing and cooking their own meals. Further to that inspection, arrangements had been successfully put in place to facilitate residents to have each of their meals now prepared and cooked in the centre. A choice of meals was agreed in advance with residents through menu planning meetings each week. A menu planner was observed on the notice board in the kitchen. There were provisions in the centre for staff to cook resident meals and an adequate supply of refreshments and snacks were available. Staff spoken with reported that they enjoyed cooking for the residents, who also enjoyed the aroma and experience of their meals being prepared in the centre.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The person in charge had ensured that two residents identified to transition from the centre to a new home within the community received appropriate support. Transition plans for the two identified residents were at an advanced stage, having commenced in 2022. The service manager reported that a new property had been secured and was in the final stages of being furnished. A number of familiar staff had been identified to transition with the residents to their new home. Some visits with the identified residents had been completed to use facilities in the area and to familiarise the residents with the area. This included visits to a local pub and grocery shopping in the area. A discovery process had been completed with the two residents and their families. This assessed the individual residents' needs and preferences in relation to their future life plans as they transition to live in their own home within the community. The provider had put in place a 'transforming lives' lead who was responsible for coordinating the de-congregation process. A number of management and staff had completed enhanced quality 'good lives' training for de-congregation. The residents transition plans included pictures of their new home and the surrounding area.

Judgment: Compliant

Regulation 26: Risk management procedures

There were suitable risk management arrangements in place. Individual and environmental risk assessments had been completed and were subject to review. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There was evidence of a regular hazard inspection. It was noted that incident trends and actions taken were reviewed and discussed at staff meetings to reduce likelihood of a re-occurrence. Risk management and incidents were a standing agenda item for staff meetings.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable precautions had been put in place against the risk of fire. Fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company. There were adequate means of escape and all exit routes were observed to be unobstructed. A procedure for the safe evacuation of residents was prominently displayed. Fire drills involving residents and staff members had been completed at regular intervals and the centre was evacuated in a timely manner. Personal emergency evacuation plans, which adequately accounted for the mobility and cognitive understanding of individual residents were in place. The inspector reviewed training records which showed that all staff had received appropriate training.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal support plans for each of the residents were in place and included detailed assessments of healthcare, communication, personal social care and support needs and choices. The personal plans had been reviewed in the preceding 12 month period in line with the requirements of the regulations. However, personal goals identified for some of the residents were not specific or measurable. For example, goals identified for one resident included to increase independent living skills and to explore involvement within the community. For another resident who spent a number of nights each month in their family home, it was noted that goals identified were for completion while in day service with the staff there. Progress in achieving some identified goals was not always recorded. It was noted that discussions with families at recent personal plan review meetings on specific interests and activities for individual residents to engage in, had not been included in goal recording sheets. Activity logs for some residents had not been appropriately recorded. While recognising a number of the residents presented with complex needs, engagement for some residents within their local community was limited and did not always

support these residents to develop a valued social role within the community. This is discussed further under Regulation 13.

Judgment: Substantially compliant

Regulation 6: Health care

The residents' health needs were being met by the care and support provided in the centre. The person in charge and CNM 1/ deputy manager were registered staff nurses and there were two further staff nurses on the staff team to support the residents healthcare needs. Detailed health action plans were in place. Records were maintained of all contacts with health professionals. Hospital passports were in place with appropriate detail should a resident require transfer to hospital. There was evidence of dietician input for one of the residents whose weight was being monitored.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional support. However, the limited space in areas and layout in the centre on occasions negatively impacted on staffs' ability to support residents to manage behaviours. The behaviours of all four residents could be difficult for staff to manage in a group living environment. Overall, incidents appeared to be well managed and residents were provided with appropriate support. There had been two peer-to-peer safeguarding incidents in the preceding 12 month period. Behaviour support plans were in place for residents identified to require same and these contained detailed proactive and reactive strategies to support residents. As outlined under Regulation 13, specific guidance in relation to a residents routine and activities were not being followed. The behaviour support plans had been devised and recently reviewed by the providers' clinical nurse specialist in positive behaviour support. A record of presentation and any triggers to behaviours, etc. was submitted to the clinical nurse specialist in behaviour support following all incidents to allow trending so as to inform behaviour management.

There were no plans to admit any new residents to the centre following the planned transition and discharge of the two identified residents from the centre. It was considered that the additional space and individualised living arrangements for the remaining two residents would enhance behavioral support arrangements in place. There was a restrictive practice register in place which was reviewed at regular intervals. It was noted that there was a multi-disciplinary team decision making process regarding the use of restrictive practices. Individual rights assessments had

been completed for restrictions in place. Reduction plans for some restrictive practices were considered. Restrictive practices were a standing agenda item for all staff meetings were it was noted assessed need and rationale for restrictive practices were discussed. .

Judgment: Substantially compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. Safeguarding information was on display and included information on the nominated safeguarding officer. It was noted that safeguarding was discussed at staff and resident house meetings. There were safeguarding plans in place with good detail to guide staff in supporting residents' safety. As referred to under Regulation 7, it was noted that a number of the residents presented with some behaviours which could on occasions be difficult for staff to manage in a group living environment and could have a negative impact on other residents. However, overall incidents were considered to be well managed. There were appropriate arrangements in place to respond, report and manage any safe guarding concerns. Staff spoken with were knowledgeable about safeguarding procedures and of their role and responsibilities. The provider had a safeguarding policy in place.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for SVC - BW OSV-0004028

Inspection ID: MON-0041265

Date of inspection: 15/04/2026

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 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: 1. In relation to Supported Individual's access to community the PIC has enhanced the current activity tracker to ensure that the supported person is offered a variety of community activities and that these when offered or declined are clearly documented. This is currently in place and is reflective of the individual's choice. 2. The supported individuals will continue to access local community facilities on foot. Positive risk taking is in place to ensure safety, and this will be monitored by the PIC and CNS in PBSP. Evening and weekend activities can be facilitated via service transport or on foot as per individual's will and preference. This will be reviewed by PIC on a monthly basis and by the PPIM during 6 monthly Nominee Provider Visit. 3. PIC, PPIM and Service Manager to discuss the issue of transport and availability of same for Beechview, possibly with the view to creating a shared timetable among other transport services within Avista.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. Painting schedule in place, Beechview will be prioritized and painting will be completed by December 2026. 2. PIC has obtained quotation for the two damaged sofas and is awaiting approval for same.	

3. The supported individual who resides in his own apartment does have access to a bath if he wishes, however this is in another part of the house. PIC and Service Manager are currently exploring the purchase of a preferred Parker Bath suitable for his living environment and his preference.

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:
Person-Centred Planning (PCP) Action
The Person in Charge (PIC) will organise a Person-Centred Planning (PCP) meeting in collaboration with the Day Service by the end of December 2026. Families will be invited to participate again to provide further input in supporting each individual's wishes, preferences, and future aspirations.
A PCP goal tracker system, as outlined in the PCP policy, will be implemented to ensure that individual goals are actively monitored and progressed. This system will be reviewed regularly by the PIC and the Person Participating in Management (PPIM) to ensure ongoing oversight and effectiveness.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Positive Behaviour Support Plan (PBSP) Review

The supported individuals' Positive Behaviour Support Plans (PBSPs) will be reviewed on a regular basis, with a clear emphasis on ensuring that activity recommendations are implemented in line with each individual's will and preferences.
Ongoing input and collaboration will be maintained with the Clinical Nurse Specialist (CNS) in Positive Behaviour Support to monitor the effectiveness and progression of

these recommendations, ensuring they remain person-centred and responsive to each individual's needs.

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Substantially Compliant	Yellow	31/12/2026
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/12/2026
Regulation 13(2)(c)	The registered provider shall provide the	Not Compliant	Orange	31/12/2026

	following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.			
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	31/12/2026
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	31/12/2026
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	31/12/2026