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 - RC/TL
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Announced
Date of inspection:	06 January 2026
Centre ID:	OSV-0005548
Fieldwork ID:	MON-0039712

About the designated centre

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

The designated centre comprises two houses in a suburban area of North Dublin. The centre provides full-time residential services for up to five individuals. The first house is a two storey, four bedroom house in a quiet community estate. This house is home to one resident. The second house comprises of a four bedroom bungalow which is located on its own grounds within a campus based setting, operated by the provider. Residents in each of the houses have their own bedroom which had been personalised to their own taste. Each of the houses are located a short distance from a wide variety of local amenities and public transport infrastructure. Residents availing of the services are supported through a staff team which is comprised of a person in charge, social care workers and care assistants.

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
Tuesday 6 January 2026	09:30hrs to 18:30hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This announced inspection was carried out in the designated centre SVC RC/TL to inform a decision on the provider's application to renew the registration of the centre. The inspection was also completed for the purpose of monitoring the provider's ongoing compliance with The Health Care Act 2007 (Care and Support of Residents in Designated Centres For (Children And Adults) With Disabilities) Regulations 2013. In the main the findings were that the provider is meeting the requirements of the regulations. Areas in need of improvement were identified on inspection in individual assessments and plans, governance and management and written policies and procedures.

The centre is currently registered for a maximum of five residents. On the day of inspection there were four residents living between the two premises with one vacancy. The inspector was able to meet with and speak to two of the five residents, the person in charge, person participating in management, service director and two of the front line staff team.

The centre is made up of two premises. The first premises is a located in a large housing estate in Co. Dublin. This premises consisted of a kitchen/dining area, sitting room, utility space and toilet on the ground floor. On the second floor there were three bedrooms one of which was en suite, a separate bathroom and staff office. The second premises is located on the provider's campus also in Co. Dublin. On the ground floor of this location there was a kitchen and utility space, two bedrooms, a shower room, sitting room and a staff break room. The second floor consisted of a bedroom, bathroom, staff office and a sitting room. A store room in this location was not noted on the floor plans submitted to the Chief Inspector. New floor plans have been submitted to the Chief Inspector of Social Services in the days post inspection that correctly identify this space.

On arrival at the first premises the inspector was met by the person in charge, the resident had already left for their morning activity. The inspector completed a walk around with the person in charge. The inspector observed that the resident's home was warm, well maintained and decorated to their liking. The inspector observed evidence of the resident's favourite sports team and photos throughout of the resident and their loved ones.

The resident returned home to have lunch and during this time sat with the inspector. The resident told the inspector that they are very happy in their home. The resident gave the inspector examples of what activities take place each week. They spoke about using the gym, going to mass, attending drama and pottery groups and meeting a friend each week for dinner. The resident is currently living alone in the premises and is staffed 2:1 at all times as a result of an incident in the past. The resident indicated that they are happy with their staff team. At all times

the inspector observed person centred, friendly interactions between the staff and the resident.

In the afternoon the inspector moved to the second location. On arrival the inspector was met with the person in charge, one resident and a front line staff member in the kitchen. The staff member and resident were cooking in the kitchen. The inspector had a brief conversation with the resident and staff member. The resident appeared happy and comfortable in the company of the staff member. The resident indicated to the inspector that they were happy in their home. The inspector then completed a walk around of the premises with the person in charge. The premises was clean and well maintained. The provider had also implemented the upgrades to the kitchen of this premises as outlined in their compliance plan from the previous inspection.

The inspector briefly observed two residents over dinner time at the kitchen table. The residents appeared happy and comfortable in each others presence enjoying their meal.

The next two sections of this report will outline in greater detail the governance systems the provider has in place and how these systems impact on the quality and safety of service provision

Capacity and capability

The provider had a clearly defined governance system in place that outlined roles and responsibilities for each level of governance. The provider had made changes to the local management team in late 2025 which were in place on the day of inspection.

The person in charge has oversight responsibility for both locations and reports directly to the person participating in management. The inspector reviewed the systems the person in charge is implementing and was assured they have the capacity to manage both locations.

The provider had systems in place in regard to auditing systems including internal six monthly unannounced inspections and an annual review. However, not all actions identified in local audits were completed within the provider's specified timelines.

The provider had ensured a full staff team was in place for both premises. However the inspector observed evidence of inconsistent team meetings since June 2025. Team meeting agendas also required review. The provider had made their own internal recommendations with regard to staff supervisions. These recommendations were not completed on the day of inspection.

A serious incident occurred in one of the locations in early 2024. While internal and external investigations are ongoing, not all recommendations that have been made to date have been implemented by the provider.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted within the specified timeline all documentation required for the renewal application of their registration to be assessed.

The floor plans for the centre had omitted one store room in one location. On the day of inspection this was identified with the person in charge. In the days after the inspection updated floor plans were submitted to the Chief Inspector.

The provider had submitted with their application the statement of purpose, insurance documents, residents guide, information on the management team and the appropriate renewal application form.

Judgment: Compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The provider had submitted evidence of payment of their annual fee.

Judgment: Compliant

Regulation 15: Staffing

The centre had no vacancies on the day of inspection. As part their oversight responsibilities the person in charge maintains a planned and actual roster in each premises.

On the day of inspection the inspector reviewed rosters in each location for November, December 2025 and the planned roster for January 2026. On review of the rosters the inspector observed limited agency use. The contingency plan for both planned and unplanned leave consisted of a panel of familiar relief staff. The inspector observed no evidence of new staff needing to be inducted into the centre which helped promote a continuity of care for the people using the service.

On further review of the rosters, team meetings and training dates for staff were identified in the planned rosters of both locations for January 2026.

The inspector had the opportunity to speak to staff in both locations. In both locations staff spoke positively regarding their roles. Staff could speak confidently and competently regarding diagnosed conditions of the residents. The staff spoken with also showed an understanding of key resident plans.

The inspector observed evidence throughout the day in both locations of positive interactions between residents and staff. In both locations residents appeared comfortable and happy with the staff teams.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that the front line staff teams had been in receipt of mandatory trainings. The trainings completed had been logged in a training matrix. This matrix was the responsibility of the person in charge to oversee and schedule refresher training as required.

The inspector reviewed the training matrix on the day of inspection. The inspector observed evidence of completed training for the staff team in areas such as the following:

- Fire Safety
- Protection and Welfare
- Medication administration
- Manual Handling
- Behaviours of concern

The inspector also observed the provider's plan for refresher training for the staff teams. Hand hygiene training was planned for the staff team. One staff member required a refresher in protection and welfare training and this was scheduled for January 2026.

One staff member required training in the safe use of an evacuation chair which is in use in one location. The inspector saw evidence that this training has been scheduled and the staff member had an adjusted roster until the training is complete.

The inspector also reviewed a sample of three staff supervision records. Supervision sessions reviewed contained discussions including checking in with staff, policy updates, risk management and training.

Judgment: Compliant

Regulation 22: Insurance

The provider had in place all required insurance documents. These documents were reviewed by the inspector prior to the inspection process.

Judgment: Compliant

Regulation 23: Governance and management

The provider had in place a governance structure with defined roles for each level of management. The person in charge reported to the person participating in management who in turn reported to the director of services.

In addition the provider had in place six monthly unannounced audits and an annual review in line with regulatory requirements. Management meetings were scheduled between the person in charge and the person participating in management as well as meetings with the local teams.

The inspector reviewed a sample of all scheduled meetings occurring in the locations as well as the provider led audits. The inspector was not assured that actions outlined in audits were being completed in line with identified timelines. The inspector also observed that meetings were not taking place on a regular basis in particular with front line staff teams.

On review of the provider led audits, actions were identified in both the March and September 2025 audits around painting of a front door, improvements to supervision processes and removal of a children's centre medication policy. On the day of inspection these actions had still yet to be completed despite timelines identified lapsing.

The provider led audits identified that staff members were due to have two supervision sessions each by the end of 2025. On review of supervision records this had not been achieved. The inspector was shown evidence of a planned supervision schedule for 2026.

A serious incident had occurred in the centre in early 2024. While internal and external investigations are ongoing in this regard, some initial recommendations had been made in October 2025. This included that all staff supervisions were to include scenario planning and the management of adverse incidents. On review of the supervision sessions carried out post the recommendations being made, the proposed agenda items had not been discussed.

The inspector also reviewed a sample of the governance meetings occurring in the centre. Staff meetings were not being carried out on a consistent basis since June 2025. One team meeting had occurred since June 2025 with a meeting in November 2025. On review of this meeting there was no evidence of a full agenda as with meetings earlier in 2025.

The inspector did observe evidence of a full schedule of meetings in place for 2026 with the scheduled date for the January 2026 meeting matching that on the January roster.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose is an important document that outlines what the residents and their representatives can expect from the provider.

The inspector reviewed the statement of purpose on the day of inspection to support the recommendation regarding the renewal of registration for the centre. The last review occurred in November 2025. The document contained the information regarding the person in charge, the person participating in management and the service provider.

The document also contained key information regarding the complaints process, what the residents can expect in terms of services provided both internally and community access.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had in place a suite of written policies in line with the regulatory requirements that helped inform and guide practices in the designated centre. On the day of inspection the inspector reviewed the schedule 5 policies.

The inspector observed that the provider had policies in place in areas such as:

· Admissions

· Safeguarding

· Restraint free environment

· Medication

· Finance

· Incident management

All of the policies reviewed had a corresponding sign sheet to indicate that staff team had read and reviewed the policies.

While most of the policies reviewed by the inspector had been reviewed in line with the regulation, some of the policies were found on the day of inspection to require review. These policies were submitted to the inspector in the days after the inspection showing they had been reviewed in line with policy requirements.

Judgment: Compliant

Quality and safety

The provider had, in the main, implemented systems that ensured the residents were in receipt if a quality and safe service.

The provider had ensured both locations were laid out to meet the needs of the residents including additions to one location that promoted resident safety in an emergency.

Systems were in place regarding supporting residents with behavioural needs. The provider had also reported in line with their own and national guidelines, all incidents of a safeguarding nature.

However, improvements were need in the area of risk assessments and care plans.

Regulation 17: Premises

In the previous inspection of this designated centre, the provider had committed to a refurbishment of the kitchen area of one location. The inspector observed that the refurbishment work had been completed.

The inspector completed a walk around of both premises and observed that each resident had their own bedroom. The inspector observed evidence that each room was decorated to the residents' choosing. In the bedrooms there was evidence of favourite sports teams, hobbies and photographs of residents' families.

The inspector observed evidence of the provider ensuring residents can remain in their homes for as long as possible. For example an evacuation chair was in use in one location to ensure that a resident could be evacuated safely in an emergency.

Both locations were clean and well presented. One location required painting of a front door that was outlined in regulation 23: Governance and Management.

Judgment: Compliant

Regulation 20: Information for residents

The provider had ensured to develop a guide for the residents that was available to all and in an accessible format.

This important document for the residents and their representatives was last reviewed in September 2025 and included key information such as the contact information of key provider representatives.

Also contained was information on the facilities the provider offers and how the residents are supported to access their local community. The document also discussed how the residents can be involved in the day to day running of their home and the complaints process if so required.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had ensured that all residents in the centre had in place individualised assessments and corresponding plans. These documents were subject to review and update from the person in charge and front line staff team as part of their roles and responsibilities.

The inspector reviewed the assessments and plans in place for the residents in both locations. The inspector observed that the assessments and plans in both locations required review.

In one location where a serious incident occurred a resident had a number of associated risk assessments in place. The inspector observed that the assessments were not scored in line with using an evidence based approach. For example, one assessment was in place for assaultive behaviour. The assessment was scored as a high risk despite one incident of the identified behaviour since July 2024. Each of the assessments reviewed by the inspector had an initial descriptor outlining a serious incident in 2024.

There was also evidence that control measures identified in the assessments were not used to accurately score the overall risk. For example assessments were in place for damage to property and threatening behaviour. The inspector observed that both assessments used the exact same control measures yet both had a different overall score. For one of the assessments the likelihood was scored as a three but yet there was no evidence of the identified behaviour occurring.

A resident had an individual preference and needs assessment in their plan. There was no date included as to when this document was completed. However, on review it was apparent that the information contained in this assessment of needs was not reflective of the most recent assessments and plans in place for the resident.

A resident had a number of plans in place that required daily recording from the staff team. These plans included daily recording of physiotherapy exercises and sleep charts. These plans had numerous gaps in their recording. For example, the recording of the physiotherapy exercises occurred for eight days in November 2025 and seven days in December 2025.

Another plan reviewed by the inspector also showed that assessments in place were subject to copied and pasted control measures. The scoring of these assessments in terms of likelihood and impact were also the same in each assessment.

Gaps were also observed in the recording of required data that helped inform care plans. For example, the inspector observed two different versions of a night time monitoring system for one resident. Both versions contained gaps in their recording. Gaps were also observed in weekly weight recording and speech and language progress notes.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had ensured that where required residents were in receipt of behaviour supports. These supports took the form of a behaviour support plan that was reviewed by the provider's behaviour support specialist.

The inspector reviewed behaviour support plans in place in both locations. Plans had last been reviewed in November 2025. One resident was reviewed weekly by the provider from a behaviour perspective.

Behaviour support plans were observed to be detailed for residents. Plans outlined in detail the background information for the residents and what information was used to support the building of an informed plan.

Environmental supports were outlined that clearly identified physical, inter-personal and programmatic aspects. Proactive and reactive strategies were in place that

informed and guided staff practice. Staff spoken with on the day of inspection were able to discuss these strategies with the inspector.

The plans also identified resident presentation and associated behaviour and staff response using a traffic light system. Each colour of the system provided detailed and relevant information for the staff teams.

Plans reviewed also contained information regarding the numbers of behavioural incidents that occurred for each resident. This allowed for successful tracking and trending of incidents and provided an overview of the success of each plan.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in place that identified, reported and implemented measures to ensure residents were free from abuse. On the day of inspection the inspector reviewed two open safeguarding plans from one location, a system implemented by the provider regarding frequent allegations made by a resident and individual plans aimed at keeping residents safe such as intimate care plans.

The provider had also ensured all members of the staff teams had been in receipt of both initial and refresher safeguarding training.

In reviewing the active safeguarding plans the inspector was assured of the reporting process. Both incidents were reported through the providers safeguarding channels to the Health Service Executive's (HSE) online safeguarding portal. Interim safeguarding plans were in place and agreed by the HSE safeguarding team. The safeguarding plans were accessible to the staff team. The inspector also observed evidence of previous safeguarding plans reviewed, agreed and closed by the HSE safeguarding team.

In one location the provider supports a resident who has made allegations. The provider had developed a system that allows them to screen each allegation and decide on the appropriate level of reporting required. An online form is completed with a list of questions regarding the allegation. Since its development in September 2025, 118 forms have been completed. These are reviewed by the person in charge, safeguarding officer and the provider's behaviour support specialist. The inspector observed evidence of these reviews informing the resident’s behaviour support plan.

The inspector also reviewed a sample of the intimate care plans in both locations. The plans are both individualised with evidence of individual preferences observed. Plans outline resident preferred supports regarding toileting, showering and oral care.

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
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for SVC - RC/TL OSV-0005548

Inspection ID: MON-0039712

Date of inspection: 06/01/2026

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Actions from the Provider visit Audits from March and September 2025 will be reviewed by PIC/PPIM and followed up on/actioned. Team meeting has occurred in January and a staff meeting schedule is in place for team meetings for the rest of the year. Children's Medication policy has now been removed from Medication folder. Shared Learning and Actions for Implementation from Incident Reviews to be implemented. Recommendation for scenario planning and management of adverse incidents are now a standing item for agenda for staff supervision meetings Supervision schedule in place for 2026. All staff members will have their first supervision meeting completed by 31/5/2026, with two supervisions for each staff being completed by 31/12/2026.	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:	

All recording charts in individual personal plans will be reviewed and monitored by PIC and staff team to ensure they are completed accurately.

All Risk assessments for each individual will be reviewed by PIC and relevant staff team members using a dynamic and evidence-based approach to ensure risk descriptors and overall risk are scored accurately and fairly.

All Residents Individual preferences and needs Assessments (IPNA) will be reviewed by the PIC and relevant staff team members and each assessment will be signed and dated.

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/05/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and	Not Compliant	Orange	30/04/2026

	support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/05/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	30/05/2026
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out	Not Compliant	Orange	30/05/2026

	pursuant to paragraph (6).			