



# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

Name of designated centre:	Oakvale
Name of provider:	Health Service Executive
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	28 January 2026
Centre ID:	OSV-0002463
Fieldwork ID:	MON-0045847

## About the designated centre

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

Oakvale provides high support residential care for up to 28 adults with an intellectual disability and/or autism and acquired brain injury. Oakvale is comprised of five separate bungalows located in a campus setting in County Cork. All 5 bungalows are joined by a link corridor. Two of the bungalows have five bedrooms while three of the bungalows have six bedrooms. Within each bungalow there is a kitchen/dining room, sitting room, bedrooms and bathrooms. All bedrooms are single occupancy rooms. Oakvale is the residents' home and is open twenty four hours a day, 7 days a week. Residents are supported through a medical model of care. The staff team is comprised of nurses and health care assistants who provide support to residents by day and night.

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

Number of residents on the date of inspection:	27
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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 28 January 2026	09:05hrs to 18:15hrs	Deirdre Duggan	Lead
Wednesday 28 January 2026	09:05hrs to 18:15hrs	Conor Dennehy	Support

## What residents told us and what inspectors observed

From what inspectors observed, residents in this centre continued to receive adequate day-to-day supports in their home. However, as noted on previous inspections, some residents continued to be impacted by an ongoing lack of appropriate activation, including regular community access. The provider had not taken adequate action to address the underlying issues and had not made sufficient progress with some aspects of compliance plans submitted previously. Ongoing non compliance was identified in residents' rights, general welfare and development, governance and management and notification of incidents. Some improvements were noted in areas such as staff training and personal planning.

This designated centre is a large building comprised of five individual units called bungalows linked by a central corridor. A sensory room, multi-purpose activity room and staff offices are based in a communal area of the centre. The centre is campus-based and each bungalow has its own dedicated entrance as well as a connecting door to the main centre. The centre is registered to provide accommodation for twenty eight residents. Twenty-seven residents were living in the centre on the day of this inspection. One resident was in hospital at the time of the inspection and staff from the centre were supporting this resident there. At least one inspector visited every bungalow and inspectors met or observed all 26 residents present, interviewed eleven staff and also met others briefly as they went about their duties. Some residents chose to interact with inspectors at length, others chose not to and this was respected. Inspectors also observed staff practices and interactions with residents, reviewed documentation and met members of the management team.

Residents were observed to spend time in their bedrooms and in the communal areas of their homes. One resident was on bed rest as part of a support plan for skin integrity. Throughout the day staff were seen to support residents with getting ready for their day, attend to personal care, administer medications and assist residents with mealtimes. Housekeeping staff were also observed attending to daily cleaning and upkeep of the centre and the centre was seen to be very clean throughout. It was noted that some bungalows had notices directing visitors to call prior to entering. When one of these numbers was tried, the inspector got through to a kitchen in the main campus. Residents in some bungalows received their breakfast from a main kitchen while staff were seen to prepare breakfast for other residents on-site.

One resident had a preference to sleep in the dining area of their bungalow. Due to the preferences and specific complex needs of this resident a bed was moved to this room each night and this was part of an overall plan to eventually have the resident sleep in their own bedroom, having previously slept on a couch or mattress in the dining room. While it was indicated to an inspector that this did not overly impact

other residents, the inspector was told that if other residents got up before this resident was awake that they would have to have their breakfast in the sitting room.

The centre had facilities such as an activity room and sensory room available to them. One resident was observed to use the sensory room on the afternoon of the inspection but this room was not seen to be in use for the remainder of the day. Records indicated that some residents were offered the use of this room occasionally and the management told inspectors that an issue with heating in this room was being rectified. As noted on previous inspections, some residents were supported during the day to leave the centre for short excursions such as a planned drama class, shopping or coffee out and a small number were supported to attend external day services. However, most residents spent the majority or all of their day in the centre. Given this, the inspectors saw that in some bungalows there were limited efforts to stimulate or offer activity to residents.

For example, an inspector noted that in one bungalow residents were brought to the dining room for a main meal and returned to the same locations they had previously been in afterwards and these residents spent a good deal of time in the sitting room with the television turned on. One staff member described a residents' shower as "the highlight" of their day. Similar observations were made by the second inspector in other areas of the centre that they spent time in and it was noted that some staff did not significantly interact with residents while supervising them or supporting them with their basic care needs. One resident was seen to be left sitting alone in a quiet room for a period of time with very little stimulation or engagement offered to them, despite a number of staff being available at the time. When the inspector approached this resident, it was clear that they enjoyed interaction but would require staff who were familiar with their communication needs to interact meaningfully. It was noted that in this bungalow an agency staff member was seen to make good efforts to interact and chat with another resident while supporting them with a meal and to make a phone call.

However, in contrast to this some very positive interactions were observed in some of the bungalows. Although one bungalow seen to be very busy due to the assessed needs of residents, staff there were observed interacting on a constant basis with residents, laughing and joking with them and singing to them. In another bungalow, staff were observed to interact with residents in a warm and respectful manner and to provide them with choices. For example, one resident requested to watch a movie and this was put on for them. Staff were heard informing residents about the inspection using a "nice to meet you" document provided by an inspector. When a resident became upset, a staff member was observed to provide reassurance and encouragement to them. A resident was supported warmly and kindly by staff to communicate with the inspector and sing an Irish song, lending a jovial atmosphere to the communal area they were present in. A resident that smoked was supported to go outside to a designated smoking shed and interact with staff while doing so and a staff member was observed to prepare a separate breakfast for a resident suited to their preferences and needs. Staff were also seen to be familiar with gestures and vocalisations used by some residents to communicate.

Overall, inspectors observed that residents were cared for and safe in the centre. However, despite some efforts, access to regular and meaningful on-site and community-based activities remained very limited for some residents. This was an ongoing and persistent issue identified in the centre over a number of inspections. The next two sections of this report will 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 provided.

## Capacity and capability

As noted in previous inspections of this centre management systems in place in this centre were ensuring that many aspects of the service being provided were appropriate to residents' needs. Residents' day-to-day care and healthcare needs were prioritised and this inspection found that this remained the case. However, the governance and management systems in place had not yet ensured that ongoing non-compliance with a number of regulations had been addressed and some of the plans in place to address these issues had not proceeded as set out in the previous compliance plan.

There was a clear management structure present in the centre. Front-line staff consisting of care assistants and care attendants reported to staff nurses in each unit, who in turn reported to two CNM1's and a CNM2 at centre level. These staff supported the person in charge who in turn reported to the director of services (DOS). Both of these individuals met with inspectors on the day of the inspection and presented as knowledgeable and aware of the regulatory non-compliance present in the centre but spoke about the challenges in addressing these in full. An annual review and unannounced six-monthly provider visits had been completed and the reports of these were provided to inspectors and showed that the provider had some oversight of the issues in the centre. It was clear that there were efforts by the centre management to effect change in the centre and these had resulted in some improvements for residents. For example, staff had access to a range of training, the services of an advocacy group had been engaged to work with residents in the centre on a weekly basis and a Practice Development Coordinator was due to commence with the provider in the week following this inspection. The inspectors were also told that one resident was being supported to access the Decision Support Service with the aid of an advocate. Recent management meeting minutes recorded that the issues highlighted in previous inspections continued to be discussed. However, these actions had not fully addressed some long-standing issues in the centre.

Staffing levels on the day of the inspection were good and there was a large staff team in place comprising of nursing, care and ancillary staff. The management of the centre reported that staff resources were adequate to provide for good basic

care and support for residents. However they acknowledged a persistent staff culture issue remained that was hindering progress with achieving compliance plans and this had been also highlighted in a recent report compiled by an advocacy service engaged by the provider to work with residents in the centre.

Many of the staff spoken with during the inspection had been employed in the centre for long periods of time and were very familiar with the residents that they supported. It was evident that staff cared for the residents they supported. Some agency staff worked in the centre, but inspectors were told that efforts were made to employ regular agency staff where possible. As found in the previous inspection, staffing levels were not identified as an issue during this inspection but the flexibility and ability of the staff team in place to meet the needs of residents in relation to their social needs, provision of activity, and community access in line with the statement of purpose of this centre was not fully demonstrated. This meant that residents continued to be adversely impacted despite ample transport and staff resources and other facilities available in the centre. A planned social care team had not been put in place to address these issues as outlined in previous compliance plans due to ongoing recruitment difficulties. This meant that although the number and qualifications of staff were appropriate to meet residents' needs, staffing arrangements did not yet afford for person centred, resident led services. Similarly, there were indications that the resources in place were not effectively used for the full benefit of all residents and this will be discussed further under the quality and safety section of this report.

Local management also spoke about future planning for this service and about plans in place to replace fire doors in the centre and complete planned building works to enhance the suitability of the premises for some residents. It was indicated that these plans had changed since the previous inspection but that this work would be completed in the future. Some progress was noted in that two suitable properties had been identified for residents to transfer to during building works. However there was no clear time-line or plan provided by the provider in relation to this and it remained uncertain how residents would be impacted by these plans. The lack of progress in relation to this also meant that a risk that had been escalated in 2016 remained open. While management confirmed that control measures in place meant that this did not present a significant risk on a day-to-day basis and was not currently impacting on residents in the centre, this issue did require addressing to ensure that the future needs of residents would be met in a planned and coherent manner that took into account their individual needs. This was also impacting on the management teams' plans to put in place some actions to address some of the long standing issues in the centre.

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

Registration Regulation 7: Changes to information supplied for registration purposes

Under this regulation, the register provider must notify the Chief Inspector of Social Services of a change of person participating in management (PPIM) within 28 days of the change. On 25 November 2025, the provider had submitted correspondence that a new PPIM would in place for the centre and other centres in the same locality from 1 December 2025. Despite this, the provider had not formally notified the Chief Inspector of this in the context of this designated centre at the time that this inspection occurred. This was received following the inspection.

Judgment: Not compliant

### Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training, as part of a continuous professional development programme. Staff were being provided with training appropriate to their roles and the person in charge was maintaining oversight of the training needs of staff.

The inspector reviewed details from a training matrix in respect of 70 staff that were also named on the centre roster. The records viewed indicated that overall staff had access to and had completed training in keys areas to provide for care and support of residents, including training in safeguarding, manual handling, fire evacuation, and a number of trainings to support staff in managing behaviours that challenge. Staff were also seen to have access to refresher training as required and staff spoken to confirmed they had access to training to support them in their roles.

Judgment: Compliant

### Regulation 23: Governance and management

The registered provider had not ensured that the designated centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose at the time of the inspection. Management systems in place did not ensure that the service provided was fully appropriate to residents' needs. The registered provider had also not ensured that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Despite the provider submitting a compliance plan following the previous inspection outlining how they planned to address a number of ongoing issues that had been identified, sufficient action had not been taken to address ongoing non-compliance in this centre and parts of this compliance plan remained unaddressed. This

inspection found that there was continued non compliance in this centre in a number of areas including Regulations 9, 13 and 31.

- Actions cited in previous compliance plans had not been completed in full by the provider and some areas of non compliance, particularly in relation to residents' rights, remained unaddressed.
- Plans that were in place at the time of the previous inspection had not been progressed and inspectors were told that the provider had failed to recruit a dedicated social care staff team as outlined in previous compliance plans. These staff were anticipated to have a significant impact on the provision of appropriate activity for residents, the setting and achieving of residents' personal goals, and community access for residents and promote a culture change among the staff team in the centre. The failure of the provider to implement this plan or put in place an alternative meant that a number of longstanding issues continued to impact on residents.
- There had been significant delays by the provider in addressing an escalated risk in the centre and there was significant uncertainty around the plans the provider had in place to address this.
- A supervision schedule reviewed showed that a schedule for supervising all staff was in place and had commenced for 2026. However, this record showed that some staff had not received formal supervision in over 18 months.
- As outlined in the capacity and capability section, the flexibility and ability of the staff team in place to meet the needs of residents in relation to their social needs, provision of activity, and community access in line with the statement of purpose of this centre was not demonstrated. This meant that residents continued to be adversely impacted despite ample transport and staff resources and other facilities available in the centre.

Judgment: Not compliant

### Regulation 31: Notification of incidents

The person in charge had not notified the chief inspector in writing, and within the appropriate time-frames, of specific incidents that had occurred in the designated centre. Incidents reports for a six month period and complaints records since the previous inspection were reviewed alongside information submitted to the chief inspector in the period since the previous inspection.

Under this regulation the Chief Inspector must be notified of certain events at specific time frames. These events include allegations of a safeguarding nature (which must be notified within three working days) and certain types of injuries that must be notified on a quarterly basis. Despite this, on the current inspection it was found that a matter initially raised as complaint by a resident on 18 August 2025 was of a safeguarding nature but this had not been notified to the Chief Inspector at the time that this inspection occurred. In addition, a safeguarding matter which had

occurred on 1 January 2026 was not notified until 10 January 2026. Regarding certain types, notifications of such injuries had been submitted for the second quarter of 2025 but these were only notified on 30 October 2025. As such these injuries had not been notified to the Chief Inspector in a timely manner.

Judgment: Not compliant

### Regulation 34: Complaints procedure

The registered provider had in place a complaints procedure for residents. However, the registered provider had not fully maintained a record of all complaints, including whether or not the resident was satisfied with the outcome of their complaint.

Information around complaints and the centre's complaints officer for the centre was seen on display in the bungalows visited during this inspection. The provider had a system for recording complaints that were made. An inspector reviewed this the complaints record and noted that such complaints records outlined the nature of the complaints made, actions taken and the complaints outcome in line with regulatory requirements. This regulation also requires that whether a resident who complained was satisfied with the outcome of the complaint or not must also be recorded. When reviewing the complaints records, it was noted that this information was not consistently recorded. For example, one resident had made two complaints in August 2025 but the resident's satisfaction with their complaints had not been recorded.

Judgment: Substantially compliant

### Quality and safety

This inspection found that overall this centre offered safe and good quality supports to residents to meet their day-to-day basic care needs. However, continued and persistent non compliance was found in relation to general welfare and development for residents and residents rights and this continued to impact on residents' lived experiences. Improvements required to ensure that residents were being afforded autonomy and had access to meaningful occupation on a regular basis had not occurred. Some issues were also identified in relation to some aspects of personal planning although in general improvements were noted in this area.

Overall residents continued to be cared for in a safe manner by a consistent, familiar staff team. Residents were supported by a consistent, familiar staff team. Good progress was being made with efforts to ensure that personal plans in place for residents were reflective of their care and support needs and there was

documentation such as support plans in place to provide information to staff about the care and support requirements of residents.

A number of consecutive inspections in May 2021, January 2023, February 2024 and October 2024 had identified issues in relation to residents' rights and general welfare and development, with a key issue identified being that the registered provider had not ensured that all residents had been provided with the opportunities to participate in activities in accordance with their interests, capacities and developmental needs. Despite some improvements noted the provider had not yet fully addressed this issue. Some positive findings and improvements were noted in relation to planned activities for residents and these are covered under more detail under Regulation 5. Activity records, support notes, personal planning documentation, photographs and transport records were reviewed by inspectors and inspectors observed staff practice and spoke with 11 staff members and the centre's management team during this inspection. These did show that residents were provided with opportunities for day trips, concerts and family visits throughout the previous year and this indicated ongoing improvements in the efforts to afford residents opportunities for these type of planned external activities. Residents had visited Dingle Aquarium, Fota Wildlife Park and a trip to an amusement park. More residents were now facilitated to visit their home-places and families if they wished and this was a positive improvement in the centre. A number of residents had enjoyed the Christmas period away from their centre with their families. Inspectors positively noted how the person in charge supported one resident to visit their family away from the centre on Christmas day. Also, daily records showed that a resident who had recently transitioned into the centre had recently been visited in the centre by a friend that they used to live with, in line with the transition plan in place for them. Activity records were now being audited by the provider and details of these were seen in the providers' report of an unannounced six-monthly visits.

It was evident that the management team were putting significant effort into ensuring that these events occurred for residents, including putting in place sufficient staffing and transport resources. However, on a day-to-day basis, records reviewed showed that all residents in this centre were still not being afforded equal access to the community and opportunities to leave the centre regularly, as well as regular and meaningful activation in the centre.

It was also not yet fully apparent that the facilities and resources available in the centre and on the campus were fully used for the benefit of residents, although some improvements were noted. For example, as highlighted in the previous inspection there was a well-equipped sensory room with a water-bed in the centre but activity records reviewed did not indicate this was offered to or used regularly by most residents. However, there was some evidence to show that this was being highlighted to staff and that some residents were now using this facility, albeit sporadically. Also, while staffing resources were good in the centre, staff focus was primarily on the physical care and support and protection of residents, with a much more limited focus on emotional and social needs noted.

It was clear that efforts had been made to plan and facilitate additional ad-hoc activities such as day trips, concerts and a Christmas pantomime and overall there

was a greater focus on ensuring that residents did have an opportunity to enjoy these types of experiences on occasion if they wished as part of the personal planning process. However, on a day-to-day basis there had not been adequate improvements in the level of stimulation, activity, and community access offered to residents.

Transport records showed that residents who required the use of a wheelchair bus continued to be very limited in accessing transport and this meant these residents were particularly impacted by this in relation to community access. This was not attributed to the availability of transport, but rather to the availability of enough staff that would drive these vehicles and also somewhat to the staff culture in the centre. For example, even though generally there were over 20 staff on duty per day in the centre, the person in charge told inspectors that on Christmas Day she had come in on her time off to facilitate a family visit for a resident as the arrangements in place had fallen through and there were no other staff willing to drive this resident home. It is acknowledged that priority for transport was afforded to residents to access medical appointments and prearranged visits with family.

### Regulation 13: General welfare and development

The registered provider was not yet ensuring that all residents were being offered sufficient opportunities on a day-to-day basis to participate in activities in accordance with their interests, capacities and development needs and being supported to develop and maintain links with the wider community.

Some improved findings in relation to once-off and specific planned activities are contained in other sections of this report. However, a number of issues continued to impact residents at the time of this inspection:

- Inspectors observed that there was a notable difference between the different bungalows in how staff engaged and interacted with residents. While some positive interactions were observed, in contrast in some units there was limited efforts observed to meaningfully interact with residents or provide stimulation to residents throughout the day.
- Daily notes reviewed for a resident indicated that sometimes they did not attend their external day service as planned and staff indicated that this was due to staff that drive not always being available.
- Inspectors' observations, activity records and daily notes reviewed showed that a number of residents spent the majority of their days watching TV, listening to music or moving around their units. While residents continued to access some in-house and on-campus activity such as music, drama and art, these activities were facilitated almost solely by activity instructors. When these staff were not present or the offerings were full or not of interest to residents there were very limited efforts to provide alternative activity or stimulation by the regular staff team. This was particularly evident during this inspection when activity instructors were absent. Although some residents did

go out and efforts were noted by some staff to engage residents, observations and records reviewed indicated that this was not the case for most residents on a daily basis. Inspectors were also informed that one of two activity instructor posts was vacant at the time of the inspection and that only one part-time activity instructor was available to all residents with a care staff was assigned to support this individual when they were present. This further reduced the opportunities available to residents.

Judgment: Not compliant

### Regulation 26: Risk management procedures

Overall risk was seen to be managed in this centre. However, the systems in place had not been fully effective to address all risk in the centre at the time of this inspection. Individual risk assessments were in place for residents in relation to identified risks and these were viewed in residents' files. During the introduction meeting for this inspection, it was indicated that one resident had recently moved into one of the bungalows of the centre from another centre operated by the same provider. Documentation within this resident's personal plan confirmed that they moved into this centre on 12 December 2025. While part of the residents' personal plan had been updated to reflect their move into Oakvale, the resident's risk assessments had not been updated to reflect and still referenced the resident's previous home. This was particularly noticeable for the resident's risk assessment and care plan for smoking. Discussions with two staff members and the person in charge during this inspection indicated that the resident was being supported in different locations for their smoking. For example, the person in charge indicated that the resident was to be supported with smoking at the centre's main entrance but one staff member told the inspector that a shed located just behind one bungalow was being used for this. This was despite inspectors being informed by the person in charge that this shed was locked and was not to be used by anyone for smoking. This shed was seen to be unlocked and open on the day of inspection with a staff member seen using this shed. Such observations were highlighted to the person in charge. The day following the inspection, the person in charge provider an updated smoking risk assessment and care plan for the resident dated 29 January 2026 that reflected the residents' admission to Oakvale.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

Overall, the person in charge had ensured that appropriate assessments were completed of the health, personal and social care needs of each resident and that the centre was suitable for the purposes of meeting the assessed needs of each

resident. Some improvements were required to ensure that the plans in place were fully up-to-date and informed staff practice in the centre. Also, there was some evidence that the provider was challenged in meeting the assessed needs of one resident in their current placement. Some ongoing improvements were noted in relation to personal planning for residents. The person in charge told the inspectors that work in improving the quality of these remained an ongoing priority in the centre and that staff had received training in person centred planning. Daily notes entries reviewed for 8 residents for January 2026 did highlight some activities that residents living in the centre took part in internally and externally. These included:

- Going to a shopping centre or shops for snacks
- Taking parts in an arts and crafts session
- Attending music sessions

Based on documentation reviewed for 6 residents, goals had been identified for residents through a person-centred planning process with time-frame and responsibilities assigned for supporting residents with these goals. While these goals did vary in their meaningfulness, the documentation reviewed around these indicated that most identified goals were progressed. This meant that some residents were participating in activities away from the centre on a planned basis. These included:

- A resident going to an open farm and mini zoo
- Residents visiting nearby towns and beaches
- Residents going shopping and having meals or coffee out
- Residents going to Christmas Pantomime
- Residents doing pottery
- A resident exploring a nearby Greenway

Some issues in relation to the plans in place for one resident were identified and discussed with the management of the centre during the feedback meeting:

- Information provided during the introduction meeting with management and from staff in the centre, alongside some solicited information received indicated that the provider was struggling to meet a residents' assessed needs in their current placement. Some incompatibility between residents had been identified in one unit and a resident had been referred to the Admission, Discharge and Transfer committee but at the time of this inspection no suitable alternative placement had been identified.
- A positive behaviour support plan had not been updated to reflect changes identified.
- All staff spoken with in this unit were not fully aware of the plans in place for this resident and these were not fully followed in practice. For example, this residents' communication support plan outlined that the resident enjoyed going to the shop to purchase specific items and should be offered this daily. While this was seen to be carried out on the day of the inspection, records reviewed indicated that this was not occurring daily as outlined in their support plan. Staff spoken with also confirmed that this was not a daily practice in the centre and would occur once or twice a week and did not

appear to be fully aware of the plan in place. This was also not fully in line with the information in place around supporting this resident to manage their behaviour and this had the potential to impact both the resident and those that they shared a home with.

Judgment: Substantially compliant

## Regulation 8: Protection

Since the previous inspection of this centre in October 2024, the Chief Inspector had been received 34 notifications of a safeguarding nature. Some of these notifications resulted in active safeguarding plans being in place for this centre based on information provided verbally to inspectors by the person in charge during the introduction meeting for this inspection. An inspector reviewed documentation relating to seven of the 34 safeguarding notifications received. From the documentation reviewed, it was evident that such matters had been subject to an appropriate preliminary screening and notified to the Health Service Executive (HSE) Safeguarding and Protection Team in line with relevant national safeguarding. However, it was identified that, as already referenced under Regulation 31 Notification of incidents, an August 2025 complaint by a resident was of a safeguarding nature. This August 2025 matter had not been the subject of a preliminary screening but it was acknowledged that the relevant resident involved no longer lived in the designated centre.

The documentation for the seven safeguarding notifications reviewed, also confirmed the existence of the safeguarding plan referenced by the person in charge. Such safeguarding plans outlined measures and follow-up actions to prevent particular safeguarding matters from re-occurring. There was evidence of such safeguarding plans being acted upon. For example, one resident's manual handling care plan was updated following a particular matter although it was noted that this care plan was short in the level of guidance it provided. Discussions with staff in the bungalows of the centre, also confirmed that these staff were aware of the safeguarding plans in place. It was notable though that some of the staff comments indicated that there was some resident incompatibility in one of the bungalows. This was also reflected in some of the safeguarding notifications received from this centre since the October 2024. This is further discussed under Regulation 5 Individualised assessment and personal plan.

Information around safeguarding including contact details for the provider's designated officers (people who review safeguarding concerns and conduct preliminary screenings) was seen to be on display in the bungalows of the centre. A training matrix provided also confirmed that all staff working in the centre had completed safeguarding training.

Judgment: Compliant

## Regulation 9: Residents' rights

Overall, this inspection found that residents continued to be limited to exercise choice and control over their daily lives. The findings of this inspection indicated that residents still did not have equal access to the community or opportunity to leave the centre regularly. Some positive and negative findings in relation to activity and community access are covered in specific detail under Regulations 5 and 13. However, this issue impacted residents across all aspects of their daily lives.

Bus logs, activity records, daily records, personal plans, provider audits and a report from an external advocacy service were all reviewed as part of this inspection and inspectors also spoke with 11 staff and two members of management and observed and spoke with residents in the centre.

It was seen that the systems in place did not fully take into account residents' rights to retain choice and control over their daily lives and maintain autonomy over their daily lives and routines. For example, should residents be provided with an opportunity to leave the centre, this was at the discretion of the regular staff team. To counteract this agency staff or relief staff who would drive were put in place by management to specifically facilitate some planned activities and this indicated that the regular resources in place were not effective in facilitating residents' autonomy. There was limited choice for residents both in terms of access to alternative activities than those offered, and decision making about their own daily routines.

- Residents' routines tended to be institutional to a degree and rely on staff availability and willingness to complete specific tasks.
- There was little or no opportunity for residents to take part in spontaneous activity of their own choosing or to be exposed to or afforded opportunities for ordinary lived experiences regularly.
- Transport records, activity records and daily records continued to demonstrate somewhat limited use of the six centre vehicles by residents, despite most of the 27 residents being in receipt of around-the-clock supports in the centre and generally requiring this transport to access the community.
- Figures provided by management of the centre showed a large variance in the amount of staff who agreed to drive that were specifically assigned for some bungalows compared to others.
- Wheelchair users were still not provided with the same opportunities to access transport and the community as other residents. For example, daily records reviewed for one resident recorded that aside from weekly home visits and a medical appointment, they had visited mass once and went for hot chocolate in a nearby town on one occasion within the previous six week period, which included the Christmas season.
- Some residents' often didn't leave the centre for one or two week periods at a time and sometimes longer.
- A recent report by an external advocacy service highlighted a number of ongoing issues identified in previous inspections remained unaddressed and

that action to address known issues in relation to residents' rights and staff culture in the centre had not been fully implemented or effective.

Judgment: Not 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
<b>Capacity and capability</b>	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
<b>Quality and safety</b>	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Oakvale OSV-0002463

Inspection ID: MON-0045847

Date of inspection: 28/01/2026

## 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
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
<p>Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes:</p> <p>The provider acknowledges the error in not formally notifying the Chief Inspector and this oversight is regrettable. The Provider assures the Authority that any notifications of changes in management will be completed as appropriate and within the required timeframes. Completed 28.02.2026 ]</p>	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>At this juncture, the service has escalated the identified risks and ongoing non-compliances to the Senior Management Team. A formal process of engagement is to be initiated, involving Human Resources, Industrial Relations leads, and representatives of the relevant trade unions. This engagement is scheduled to commence on Monday, 27th April 2026.</p> <p>As this process is anticipated to be protracted, the provider cannot confirm a definitive timeframe for resolution. Accordingly, this action shall remain outstanding pending the outcome of the engagements.</p> <p><b>The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulation ]</b></p>	
Regulation 31: Notification of incidents	Not Compliant

<p>Outline how you are going to come into compliance with Regulation 31: Notification of incidents:</p> <p>A review of all incidents, complaints and safeguarding concerns has been completed to ensure that all notifiable events have now been appropriately identified, recorded and notified in line with regulatory requirements. A strengthened system is now in place to support the timely identification and notification of all incidents: A centralised tracker system is maintained to record and monitor all incidents, which is updated daily (Monday to Friday) through Centre Review Meetings. All incidents and complaints are now subject to immediate preliminary screening by the Person in Charge (or CNM2 in their absence) to determine if they meet the threshold for HIQA notification and/or safeguarding referral. A weekly review of the tracker is completed by the Person in Charge to ensure all notifiable incidents have been submitted within required timeframes. Completed 08.02.2026 ]</p>	
Regulation 34: Complaints procedure	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <p>All complaints are reviewed by the Complaints Officer and appropriate action taken. Complaints are currently removed from the booklets within the bungalows and stored centrally by the CNM3/PIC, this ensures proper oversight of the process. The CNM3 will ensure that the individual making the complaint is satisfied with the outcome and that it is recorded accurately. Completed 28.02.2026 ]</p>	
Regulation 13: General welfare and development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 13: General welfare and development:</p> <p>The Provider acknowledges the ongoing non-compliance with Regulation 13, which primarily reflects the persistent failure of the service to ensure fair and equitable access to external activities and provision of a meaningful day for residents. While some improvements have been observed, this issue remains systemic, influenced by ongoing Human Resources (HR) and Industrial Relations (IR) challenges.</p> <p>The matter will be addressed through the formal engagement process currently being initiated, involving HR, IR leads, and representatives of the relevant trade unions. At this time, the Provider is unable to provide a definitive timeframe for resolution of this action due to the complexity of the issues involved.</p> <p><b>The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulation ]</b></p>	
Regulation 26: Risk management procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p>	

Following the inspection, the resident's risk assessments and care plans, including smoking, were reviewed and updated (29/01/2026) to accurately reflect their current living environment and required control measures. To address the issues identified and ensure consistency in risk management, The Person in Charge has implemented a process to ensure that all risk assessments are reviewed and updated at the point of admission, transfer, or significant change, to reflect the resident's current environment and support. Control measures relating to smoking have been clearly defined and standardised, including the designated smoking location, and this has been communicated to all staff. The shed referenced during inspection has been secured and designated for storage purposes only, and staff have been clearly instructed that it is not to be used for smoking under any circumstances. Risk assessments are now subject to regular review and oversight by the Person in Charge, with a focus on ensuring they remain current, location-specific and clearly understood by staff. In addition, a monthly audit of risk assessments has been implemented to ensure that all identified risks are appropriately assessed, documented and consistently managed in practice. Completed 28.02.2026 ]

Regulation 5: Individual assessment and personal plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:  
 The Management Team has reviewed the residents' current placement and identified compatibility issues within the bungalow. This matter has been escalated to the Admissions, Discharge and Transfer Committee, and the resident remains under active review. Any suitable vacancy arising within the service will be considered to support an alternative placement, where appropriate.  
 Actions being implemented:  
 1. Multidisciplinary Case Conference: A case conference will be convened to review the resident's assessed needs and update the Positive Behaviour Support (PBS) Plan and Communication Support Plan to ensure they reflect current needs.  
 2. Communication and Staff Guidance: Revised plans will be communicated to all staff, with guidance provided to ensure consistent understanding and implementation in practice.  
 3. Monitoring of Supports: Daily notes and activity records will be reviewed to confirm planned supports are delivered consistently, and any deviations are promptly addressed.  
 4. Oversight of Personal Plans: The Person in Charge, supported by the CNM, will maintain ongoing oversight of personal plans and associated records to ensure they remain current and effectively guide practice.  
 These actions aim to ensure the resident's personal plans are up to date, clearly communicated, and consistently implemented in practice.  
 Completion Date: 30.06.2026 ]

Regulation 9: Residents' rights	Not Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:  
 At this stage, the service has escalated the identified risks and ongoing non-compliances to the Senior Management Team. A formal engagement process is being initiated, involving Human Resources, Industrial Relations leads, and representatives of the

relevant trade unions. This engagement is scheduled to commence on Monday, 27th April 2026.

As this process is anticipated to be protracted, the provider cannot confirm a definitive timeframe for resolution.

As part of this process in alignment with Regulation 9 – Residents’ Rights, following a comprehensive review of practices, staffing arrangements, transport utilisation, and daily routines will be undertaken to address the systemic issues identified will be tabled.

Actions aimed to to embed a sustainable culture of rights-based practice, ensuring that residents are supported to exercise choice, autonomy, and equal access to meaningful opportunities, in full compliance with Regulation 9 – Residents’ Rights will be confirmed following the IR/ER engagement

**The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulation ]**

## 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
Registration Regulation 7(3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the designated centre) within 28 days of the change and supply full and satisfactory information in regard to the matters set out in Schedule 3 in respect of any new person participating in the management of the designated centre.	Not Compliant	Orange	28/02/2026
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access	Substantially Compliant	Yellow	

	to facilities for occupation and recreation.			
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	
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	
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	Not Compliant	Orange	

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	
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	28/02/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation,	Not Compliant	Orange	28/02/2026

	suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	28/02/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	28/02/2026
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	Substantially Compliant	Yellow	30/06/2026

	accordance with paragraph (1).			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	
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 pursuant to paragraph (6).	Substantially Compliant	Yellow	28/02/2026
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	