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:	DC4
Name of provider:	St John of God Community Services CLG
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	18 May 2026
Centre ID:	OSV-0002936
Fieldwork ID:	MON-0045282

About the designated centre

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

St John of Kildare services - DC 4 is located on a campus based setting within walking distance of a large town in Co. Kildare with a number of local amenities. The designated centre is a large, purpose-built residential building divided into four units. The current capacity of the centre is 17 in line with the centre's de-congregation plan. DC 4 provides services to adults whose primary disability is intellectual disability. Residents may also have additional needs due to physical disability, sensory impairment, medical conditions and behaviours that challenge. Residents are supported on a full-time basis by a team of clinical nurse managers, nurses, social care workers and care assistants. Housekeeping and catering staff also support the team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
Monday 18 May 2026	16:20hrs to 21:20hrs	Marie Byrne	Lead
Tuesday 19 May 2026	08:00hrs to 14:45hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

This unannounced inspection was completed by one inspector of social services over the course of two days. It was carried out to assess the provider's regulatory compliance. It was also completed following receipt of information of concern, particularly relating to notifications submitted to the Chief Inspector of Social Services.

Overall the findings of this inspection were that while areas of good practice were identified, action was required by the provider to bring about improvements. Overall, the inspector found that action was required by the provider in line with their de-congregation plan as the design and layout of the centre not meeting the number and needs of residents living in the centre. Action was also required to ensure the effective implementation of the provider's systems for oversight and monitoring, to complaints management and to fire safety. These areas will be discussed later in the report.

DC4 is a residential service located on a large campus, and as such considered a congregated setting. There are also other residential services, a school, day services, a swimming pool and a number of administration buildings on the campus. The centre is a large purpose-built one-storey building split into four units. There is one front door and each of the units are connected by interlinking corridors. This centre originally accommodated 26 residents and as part of the provider's de-congregation plan this has now reduced to 17 registered beds. They had supported a number of residents to transition to homes in the community.

There were 16 residents living in the centre at the time of this inspection, with four residents in each of the units. Care and support can be provided for adult residents who may also have additional needs such as physical disabilities, sensory impairment, medical conditions and behavioural support needs.

As, previously mentioned, while the provider had plans to further de-congregate the centre in line with Ireland's national strategy, Time to move on from Congregated Settings; A Strategy for Community Inclusion (2011). However, there was limited evidence of progress relating to the provider's de-congregation plan since the last inspection. In addition, an emergency admission had been completed mid-2025. The inspector acknowledges that based on a review of documentation and discussions with staff and members of the management team, this admission was completed in line with the provider's admission policies and procedures. It was also completed in line with the statement of purpose for this centre.

It is also acknowledged that a number of works had been completed since the last inspection to reduce the institutional aesthetic of the building. For example, a number of rooms that had been recently renovated and decorated to meet residents' needs and preferences. These will be discussed further, later in the

report. However, since the last inspection a kitchen that was being developed at the time of the last inspection was now complete. This was an industrial style kitchen which was not being used by residents due to risks associated with large industrial equipment. In addition, as a result of the development of this kitchen and food preparation area, residents in one of the units no longer had access to a formal dining room. This will be discussed later under Regulation 17: Premises.

During the inspection, the inspector had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting the 16 residents living in the centre and 20 staff employed by the provider. This included, 13 staff on duty, the person in charge, a person participating in the management of the designated centre (PPIM), the director of nursing and the director of services. Observations were completed over the two days and documentation was also reviewed about how care and support is provided for residents, and relating to oversight and monitoring by the local management team and the registered provider.

On arrival, a number of residents were in day services or out-and-about in their local community. Later in the evening two residents were spending time in day service spaces with staff from this centre. This was part of the control measures in place to reduce risks relating to safeguarding in the centre. Over the course of the first evening, the inspector had an opportunity to complete a walk around the premises with the person and charge and meet 12 residents as they went about their evening routines. They were observed relaxing watching television, listening to music, using their tablet computers, spending time with each other and staff or having a head and scalp massage. On the second day, the inspector had an opportunity to meet the four residents they did not meet on the first day. They were preparing to go to day services and to engage in activities of their choice in line with their meaningful day plan.

Over the course of the inspection residents were observed to have opportunities to take part in activities of their choice at home or to leave the centre to spend time in their community. Five residents were attending day services and staffing numbers remained the same in the centre while they were gone. As a result the remaining residents had opportunities to engage with staff on a one-to- one basis, or to go out together. Each person had a meaningful day planner in place to ensure they had opportunities to take part in activities they enjoy on a regular basis. These planners included pictures to support residents to choose what they wanted to do. During the inspection, a number of residents left the centre with staff. They went out for coffee, lunch, to the hairdresser, to appointments, shopping, for a walk and to attend a local men's shed. One resident was visited by and spent time with a family member.

Based on what the inspector read and was told, residents were developing and achieving their goals. For example, there were two polytunnels on site and residents and staff had started a composting project. They had received a European award for their efforts.

There were lots of pictures and art work on display throughout the four units. There were also a number of signed rugby jerseys and pictures of residents at matches. The inspector spoke with a staff member who had arranged for residents to go to matches, meet the players, watch them training and to have lunch in a local hotel with the players.

Residents communicated in a number of ways. Staff and the person in charge were observed to be very familiar with how they communicate and how they prefer information presented to them. One resident used gestures, body movements and sounds to communicate with the inspector about going on an airplane. This goal had been reviewed at the time of the last inspection and they had taken some steps to achieve their goal such as getting their passport, visiting a local airport to watch planes land and booking a flight to a regional airport. Since then, they had taken the flight across Ireland and taken a flight abroad to go to an agricultural show. Another resident loved a particular movie and staff had dressed up and performed scenes from this movie for them. After this they had arranged for a mural of a scene from the movie to be painted on their bedroom wall by a local artist.

Over the course of the two days, the inspector heard and observed residents seeking out staff support. Staff were observed to very responsive and readily available to support them. Each staff who spoke with the inspector were found to be very knowledgeable in relation to residents' care and support needs. They spoke about residents' strengths, needs, preferences and goals. They also spoke about how residents' communicate and make choices in their day-to-day lives. Overall the inspector found that staff were motivated to ensure that each resident was safe, well cared for and engaging in activities they find meaningful.

Residents were staying in regular contact with their family and friends and this will be discussed further under Regulation 11: Visits. There was information available for them on the complaints process and how to access independent advocacy services. The provider was seeking the opinion of residents and their representatives as part of their annual review process. The inspector reviewed surveys completed by eight residents' representatives for their latest annual review. These surveys were completed in January and February 2026. Overall, this feedback was very positive. Examples of comments included, "thanks to all for your care and support for ….", "…. is in a very good place, he received optimum care" "every single support and needs are met". A sample of comments relating to staff included, "very caring and approachable staff", "staff always link with ourselves if any issues" and "we are always updated in a timely manner".

The inspector also reviewed a number of complaints in the centre from 2025 relating to laundry management and residents' safety and well-being. The inspector found that improvements were required in relation to complaints management to ensure that they were followed up on and closed, where possible, to the satisfaction of the complainant. This will be discussed further under Regulation 34: Complaints.

Overall, the inspector found that improvements continued to be made in this centre and these were leading to improved outcomes for residents. Residents had meaningful and active lives attending events and shows, celebrating milestone

birthdays and developing their life and independence skills. However, further action was required to further improve residents quality of life. Action was required by the provider to bring about improved compliance particularly in areas such as governance and management, fire safety, complaints management and the premises.

The next two sections of the report present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of residents' care and support.

Capacity and capability

The findings of this unannounced inspection were that while some areas of good practice were identified, improvements in regulatory compliance were required. The areas where action was required particularly related to the implementation of the provider's de-congregation plan for this centre, the effective use of their systems for oversight and monitoring, the premises, fire safety and the management of complaints.

During the inspection, the inspector was informed that a number of key actions were in progress relating to the premises and de-congregation plan for this centre. This included a review of the layout of one kitchen, the addition of a dining room and the provider's plans to submit an application to vary after the inspection to reduce the registered beds from 17 to 16.

The management structure was clearly defined in the statement of purpose and matched what was described by staff during the inspection. From a review of the minutes of staff meetings, handovers and through discussions with staff, it was evident that there were clearly identified lines of authority and accountability among the team. The person in charge provided supervision and support for the staff team. They were supported with the day-to-day management of the centre by two social care leaders and a clinical nurse manager. The person in charge reported to and received supervision and support from a person participating in the management of the designated centre (PPIM).

The centre was not fully staffed in line with the statement of purpose at the time of this inspection. Based on a review of rosters and discussions with staff, this was not having an impact on continuity of care and support for residents. Overall, the inspector found that the provider was recognising and responding when additional staffing supports were required.

Regulation 14: Persons in charge

The inspector reviewed the Schedule 2 information for the person in charge in advance of the inspection and found that they had the qualifications and experience to fulfill the requirements of the regulations. They were full-time had sole responsibility for the day-to-day running of this centre. As previously mentioned, they were supported with the day-to-day management of the centre by a clinical nurse manager and two social care leaders.

During the inspection, the inspector reviewed the systems they had for oversight and monitoring and found that for the most part they were proving effective. They were identifying areas of good practice and areas where improvements were required in this centre. They were implementing the actions, within their remit from the provider's quality enhancement plan.

They had worked with residents for many years and residents were observed to be very familiar with them and appeared very comfortable and content in their presence. Staff members who spoke with the inspector were complimentary towards the support they provided to them.

Overall, the inspector found they were focused on quality improvement initiatives and implementing a human-rights based approach to care and support for residents. They were also motivated to ensure that the each resident was happy, safe, engaging in activities they find meaningful and exploring their community.

Judgment: Compliant

Regulation 15: Staffing

Overall, the inspector found that the service was effectively planning, organising and managing the workforce to meet residents' needs.

For example, in response to presenting risks relating to safeguarding, the provider had implemented additional staffing. Based on a review of incidents, notifications and through discussions with staff, this had proved effective and reduced the presenting risks. This will be discussed further under Regulation 8: Protection.

The centre was not fully staffed in line with the statement of purpose but this was not found to be impacting on continuity of care and support for residents. There were one vacancy for a care assistant, one staff on long term unplanned leave and one staff on extended planned leave. In addition, staffing cover was required to cover planned and unplanned leave.

The inspector reviewed a sample of rosters for 2026 and found that they were well maintained. They also demonstrated continuity of care and support for residents. For example, the required shifts were covered by relief staff, two regular agency staff and existing staff completing additional hours.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of training and supervision to ensure they were carrying out their roles and responsibilities to the best of their abilities.

The staff training records and a sample of seven certificates of training were reviewed. These demonstrated that staff had access to training and refresher training in line with the organisation's policy and residents' assessed needs.

100% of staff had completed training identified as mandatory in the provider's policies such as safeguarding, fire safety and manual handling. Staff had also completed a number of bespoke training in the centre in areas such as positive behaviour support, fire safety, complaints, restrictive practice and risk management. In addition, members of the staff team had completed other training such as modules on a human rights-based approach to health and social care, RUA guiding principles (training focused on a human-rights based approach to identity, friendships, relationships and sexuality for people with intellectual disabilities), advocacy and the Assisted Decision Making (Capacity) Act 2015.

There was a supervision schedule in place to ensure staff were in receipt of regular formal supervision at least twice a year in line with the provider's policy. The inspector reviewed a sample of supervision records for six staff. The records demonstrated that there was discussions around their roles and responsibilities, training, safeguarding, accidents and incidents and policies, procedures and guidelines. The inspector also reviewed six-weekly meetings between the person in charge, clinical nurse manager and social care leaders. A sample of manager meetings were also reviewed where training, incidents, safeguarding and supervision were discussed.

The inspector had an opportunity to observe staff doing morning handover on the second day of the inspection. Discussions were found to be resident-focused. Discussions were held about residents' health, wellbeing, upcoming appointments and their plans for the day. They were also held around safeguarding, restrictive practices, incidents, staff roles and responsibilities for the day, the administration to PRN (as required) medicines and menu planning.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector found that some improvements were required to ensure that the provider's systems for oversight and monitoring were being effectively utilised in this centre.

As previously mentioned, there was limited evidence to show progress on the provider's de-congregation plan since the last inspection. This was discussed with the management team at the end of the second day of inspection. They spoke about meetings held, funding and a premises they were planning to complete woks to and then apply to register. They also spoke other future projects which would result in further opportunities for some residents to move to smaller houses in the community.

The provider's latest annual review and the last two six-monthly reviews for this centre were reviewed. These demonstrated that the provider was identifying areas where improvements were required. However, they had not identified some areas for improvement. For example, the annual review had not identified that complaints had not been closed to the satisfaction of complainants, that fire safety works were required or that some notifications were not being submitted to the Chief Inspector of Social Services, as required. The annual review also indicated that through observation and interview the design and layout of centre was meeting residents' needs. This was not in line with the findings of this inspection and will be discussed further under Regulation 17: Premises.

The latest six-monthly review by the provider had self-identified a number of areas where improvements were required. The action plan did not include some of these or include actions or timeframes for completion. However, the majority of these are contained in the quality enhancement plan (QEP). A review of the QEP demonstrated that 14 actions were completed and 14 actions were in progress. Nine of the 14 "in progress" actions were overdue for completion at the time of this inspection. For example, an action relating to the safeguarding log was due to be completed by 31 January 2026. The inspector reviewed the log and as described in the QEP it did not reflect feedback from the Health Service Executive (HSE), Safeguarding and Protection Team (SPT), or the closure of safeguarding plans. The inspector met with the provider's designated liaison person who showed them the feedback from the HSE SPT and the dates plans were closed to them. This was on an electronic system and the inspector was informed by the person in charge that they could not access this information to update their safeguarding tracker.

Some of the other outstanding/in progress actions in the QEP related to areas such as individualised assessment and personal plan, the premises, the replacement vehicles and fire safety. Some of these areas for improvement were first identified in 2022, with others identified in 2023, 2024, 2025 and a small number in 2026. Some of these will be discussed further under the relevant regulations.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of two months of notifications submitted to the Chief Inspector in 2025 and found that six notifications had not been submitted within the required three day timeframes. This included, five notifications relating to safeguarding and one relating to an unexpected absence of a resident from the designated centre.

The inspector also reviewed documentation in a sample of residents' plans and the provider annual review around accidents and incidents. These demonstrated that residents had sustained non-serious injuries, and these had not been notified to the Chief Inspector quarterly, as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a complaints policy which had been recently reviewed. Posters with a picture of the complaints officer and easy-read document on the complaints process were on display in the centre. The complaints procedures were also included in the statement of purpose and residents guide which was available in the centre.

Based on discussions with staff and a review of documentation, residents and their representatives were supported to understand the complaints process. The complaints and compliments folder and tracker were reviewed. The tracker indicated that there had been two compliment and three complaints. One complaint relating to laundry management had been closed. There were two open complaints from the representative of residents' currently using the service. These related to the safety and well-being of residents. The inspector was shown documentary evidence to demonstrate that these complaints had been responded to. However, for two reviewed, this was not completed within the timeframes identified in the provider's policy. The inspector was informed that complainants were satisfied with the outcome of their complaints. However, there was no documentary evidence available to demonstrate this.

The inspector also reviewed a number of compliments which were contained in annual surveys and these were discussed in the opening section of this report.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that every effort was being made by the staff team to ensure that residents were in receipt of a good quality and safe service. They were supporting them to have opportunities to take part in activities they enjoy and to spend time with their family and friends. However, as previously mentioned the design and layout of the centre was not meeting the number and needs of residents and some fire safety works were required.

The inspector reviewed a sample of seven residents' assessments and plans. These documents positively described their needs, likes, dislikes and preferences. They were being supported to set and achieve their goals. Their communication support needs and preferences were assessed and detailed in their personal plan. They had their healthcare needs assessed and were accessing health and social care professionals in line with their assessed needs.

Residents who required it were accessing the support of a psychiatrist, psychologist or clinical nurse specialist in wellbeing and positive behaviour support. There were a number of restrictive practices in place and these were being regularly reviewed.

Residents, staff and visitors were protected by the safeguarding and policies, procedures and practices in the centre. There was a system for reporting safeguarding concerns and staff had completed training to ensure they were aware of their roles and responsibilities.

Regulation 10: Communication

Based on a review of a sample of seven residents' assessments and plans, those who required it, were supported to access the relevant health and social care professionals. This included speech and language therapists and a clinical nurse specialist in wellbeing and positive behaviour support.

Residents who required them, had communication profiles created by a speech and language therapist. There was a supports strategy page and a care plans monitoring sheets in place to review the effectiveness of these.

Staff had worked with residents and health and social care professionals to assess residents' communication needs and preferences. They had explored all the ways that residents were communicating and the different ways they could support them to communicate their choices. They were supporting residents to use objects of reference, pictorial supports, social stories, tablet computers and a specific software programme with AAC (alternative and augmentative communication) solutions to empower people with speech and language disabilities to communicate. They were also using LAMH (sign language for people with an intellectual disability). as previously mentioned, on the second day of the inspection, the inspector had an opportunity to observe staff handover. During this time, staff practiced a number of practical LAMH signs.

During the inspection, staff showed the inspector a number of accessible music devices which supported residents to turn on and off their music when they wished to. In addition, a resident showed the inspector their smart device for turning on an off their television and lights.

Judgment: Compliant

Regulation 11: Visits

The inspector reviewed the provider's visitors policy and the information in the statement of purpose and residents' guide around visiting arrangements. Based on what they read and were told, residents were supported to develop and maintain relationships. They were spending time with their family and friends on a regular basis. For example, one resident was going to their family home weekly and one resident was being visited by their family member on the day of the inspection. The inspector also spoke with a staff member about their upcoming plans to support a resident to meet their family member half way between both their homes.

There were a number of private and communal spaces available to them to receive visitors. There was a visitor's room in the central area between the units. Some residents were also choosing to receive their visitors in their bedroom.

Judgment: Compliant

Regulation 17: Premises

Overall, the inspector found that the premises was not designed and laid out to meet the number and needs of residents living in the centre.

The provider was aware of this and had a de-congregation plan in place. The inspector was provided with verbal updates on next steps of the de-congregation plan at the end of the inspection. They were also informed of the provider's plan to submit applications to vary to reduce the number of registered beds initially by one, just after the inspection.

As part of control measure to reduce safeguarding risks in the centre, two residents were regularly spending time in day service buildings in the evenings and at weekends. Based on what the inspector read and was told, this was due to the environment not fully meeting their needs. For example, the inspector was told that this was due to their preferences for how they use spaces. They were also told it was due to how busy and noisy the units could be.

As previously mentioned a number of works had been completed since the last inspection to reduce the institutional aesthetic of the building. For example,

following a sensory assessment an occupational therapist had made recommendations and a sensory room was developed. For another resident who loved books and magazines, a library room was developed for them. Other examples included a beauty room and a music room. In addition, premises adaptations had been made based on the recommendations of other specialists. For example, some doors had been painted in bright colours, and padding added where required.

However, as previously mentioned the renovations that had commenced at the time of the last inspection to one kitchen were now complete. There was now an industrial-style kitchen which could not be accessed by residents due to presenting risks relating to large industrial equipment. There were two chefs and an assistant working in the centre Monday to Friday. They were preparing freshly cooked meals on these days and pre-preparing meals for the weekends which were then heated in large Bain-Marie's. As a result of these renovations, the residents in one of the units no longer had access to a formal dining room. The dining room was redesigned and now being used by chefs for food preparation. The inspector was informed that this had recently been referred to the provider's rights committee and that plans were in place to review this arrangement as part of the provider's de-congregation plan.

As outlined in the provider's latest annual and six-monthly reviews and their QEP, a number of premises works or repairs were also required. For example, painting was required in a number of areas, a review of laundry spaces was required and an alternative solution was required for the storage of wheelie bins. Some of these required actions, were first identified in March 2025.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had ensured that there were suitable fire precautions in place in this designated centre. They were aware that some fire safety works were required and were working with their funder to arrange for these works to be completed.

During the walk around of the units the inspector observed emergency lighting, smoke alarms, fire doors with swing closers, emergency exits, fire-fighting equipment and the alarm systems in place. The inspector reviewed records for 2025 and 2026 to date which demonstrated that quarterly service and maintenance were completed on the above named fire systems and equipment. The evacuation plans were on display in prominent areas. The site specific emergency plan was also reviewed and found to be detailed in nature.

A sample of four drill records were reviewed. These demonstrated that drills were occurring frequently during the day and during hours of darkness. They demonstrated that the provider was ensuring residents could evacuate in a safe and timely manner. Drills took into account residents' support needs, a range of scenarios and were completed with minimum staff levels. A repeat drill was planned

just after the inspection for one resident as they had not completed an hours of darkness drill. They had successfully completed day drills.

A sample of six residents' personal emergency evacuation plans were reviewed. These were found to be sufficiently detailed to guide staff practice to support them to evacuate safely.

The provider had commissioned a fire safety review in 2022 and had completed the majority of actions from the resulting report. The outstanding action was due to be completed after the inspection and related to compartmentalising the attic space. A business case had been submitted to their funder. The inspector was informed that the funding was being made available and their funder had advised that the provider should proceed with appointing a design team to support the works. This was in progress at the time of the inspection but no date for completion of the works had been identified.

There was evidence of ongoing work to ensure that fire doors were operational and free from damage. The doors identified as damaged at the time of the last inspection had been fixed. Some further doors had recently been identified as damaged and were due for review by the provider's residential team. This was included on the QEP for this centre.

Judgment: Substantially compliant

Regulation 6: Health care

Based on a review of documentation and discussions with the person in charge and staff on duty, residents were supported to enjoy best possible health. Their health and wellbeing was being supported through diet, nutrition and recreation.

From a review of a sample of seven residents' assessments and plans, it was evident that, as required, they had access to a general practitioner (GP) and a range of consultants and health and social care professionals in line with their assessed needs. Where treatment and recommendations were made, these were being implemented. They were being supported to have an annual health check with their GP.

They were cared for by trained staff who engage in continuous professional development, enabling them to support residents in line with their specific healthcare needs. For example, staff were trained in first aid and the safe administration of medicines.

Residents had a log maintained of all their appointment and follow ups. A sample of assessments and plans reviewed had care plans which were detailed in nature and reviewed as required. They also had a hospital passport in place.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required it, had regular access to a psychiatrist, psychologist, or clinical nurse specialist (CNS) in wellbeing and positive behaviour support. Restrictive practices were being reviewed to ensure they were the least restrictive for the shortest duration.

Significant efforts had been made to ensure that residents were accessing the supports and services they required since the last inspection. They had risk assessments and plans which were being regularly reviewed.

In response to a trend of incidents, some of which were safeguarding in nature, the provider had taken a number of responsive actions. For example, additional support was provided to the staff team by the CNS and training department. This had proved effective at reducing presenting risks. For example, a recent quarterly review by the CNS described the supports implemented and demonstrated their effectiveness through a quick downward trend of incidents between June and September 2025. It also demonstrated further decreases incrementally up to April 2026. The report used graphs to show the decrease in incidents, antecedents and the time of day when incidents were occurring. It also examined the effectiveness of additional controls implemented. For example, a trial of an increase in meaningful activities was completed which demonstrated a significant reduction in behavioural incidences.

The inspector reviewed a sample of three residents' positive behaviour support plans. These outlined proactive and reactive strategies, and included consideration on safeguarding and protection and skills building for residents. These plans outlined steps staff should take to support residents if they were anxious or distressed.

Staff had completed training and those who spoke with the inspector were aware of their roles and responsibilities and the steps to take if residents were experiencing increased anxiety or engaging in responsive behaviours.

There were a number of restrictive practices in place. Examples of these included locked doors, sensor alarms, audio monitor, lap belts and assigned seating in transport. The inspector reviewed documentation to demonstrate that restrictions were regularly reviewed by the local restrictive practice committee. In addition, as required restrictions were being referred to and reviewed by the provider's human-rights committee. For example, the restriction relating to residents not being able to access one of their kitchens and not having access to a formal dining room had been referred to the human-rights committee.

The inspector reviewed restrictive practice reduction plans which demonstrated trials to reduce the length of time restrictions were in place. There was also evidence of

the removal of restrictions. For example, a store room that was previously locked, was now open.

Judgment: Compliant

Regulation 8: Protection

The inspector found that every effort was being made by the provider and the staff team to ensure that residents were in receipt of a service where they were protected and safe.

The provider had responded to the aforementioned trend of safeguarding concerns relating to alleged peer-to-peer psychological abuse in 2025. Based on a review of documentation and discussions with staff, each incident had been reviewed and responded to. The inspector reviewed preliminary screenings, safeguarding plans and responses from the Health Service Executive (HSE) safeguarding and protection team. These demonstrated that they had been reported and followed up on in line with the provider's and national policy.

The provider had responded in a number of ways. They had developed interim and then formal safeguarding plans. They had effectively implemented the control measures in safeguarding plans such as additional staffing both day and night. Based on notification and incident trending, these measures were proving effective in reducing risks relating to safeguarding and protection in this centre. For example, following the initial spike of safeguarding concerns, there was a rapid downward trend of safeguarding concerns following the implementation of additional control measures.

From a review of the staff training records, 100% of staff had completed safeguarding and protection training. As previously mentioned, over the course of the inspection, the inspector spoke with 20 members of staff employed by the provider. This inspector found that they were aware of their roles and responsibilities should there be an allegation or suspicion of abuse. For example, the inspector spoke with the person in charge and PPIM and they each outlined their roles and responsibilities. In addition, on the first day of the inspection, the inspector met with 11 staff on a one-to-one basis. Staff described the different types and categories of abuse. The inspector described different scenarios relating to staff witnessing or suspecting abuse. Each staff described what they would do to ensure residents' immediate safety, who to report to and they documentation they would complete.

Safeguarding was an agenda item in the sample of handover, supervision, staff meetings, resident meetings and management meetings reviewed. There was easy-read information available about complaints, safeguarding, residents' rights and accessing advocacy services.

The inspector reviewed a sample of seven residents' personal and intimate care plans. These clearly detailed their preferences and any supports or assistance they may need from staff.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	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
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for DC4 OSV-0002936

Inspection ID: MON-0045282

Date of inspection: 18/05/2026

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: The Provider Nominee and senior management will ensure that annual review template will be reviewed to ensure that all regulatory requirements are included The Residential Coordinator will ensure that all complaints will be managed in line with policy and will be closed in a timely manner. The Person in Charge will ensure that all notifications are completed in line with regulation and submitted to the regulator within appropriate timeframes. The Provider Nominee will develop a detailed decongregation plan, including internal changes to Cill Seilin. All outstanding actions on the Quality Enhancement Plan (QEP) have been reviewed and escalated where actions are not completed. The provider will review the safeguarding monitoring systems to ensure all safeguarding feedback, outcomes and closures dates will be accurately recorded and accessible to the Person in Charge.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The Person in Charge reviewed all notifications required and has implemented a tracking process to ensure that all required notifications are submitted to the Regulator within the required timeframes.	
Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Residential Coordinator ensured that all open complaints were closed within the Designated Centre. This a recorded within the complaints log.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: An application to vary registration will be submitted to reduce the centre's registered capacity reflecting the revised occupancy will be submitted to the Chief Inspector 10/07/2026 The provider is progressing the decongregation of three residents to a new community-based residence to ensure residents are supported in environments that better meet their individual needs and preferences. 31/01/2027 A review is underway to ensure all residents have meaningful access to meal preparation and cooking activities, in line with their assessed needs, preferences and abilities. 30/06/2026 Following completion of this review, the registered provider will implement identified actions to improve residents' access to meal preparation, cooking and dining facilities 30/11/2026 The provider has completed and closed actions identified within the Quality Enhancement Action Plan relating to the review of laundry facilities and the storage of wheelie bins. 30/05/2026 The registered provider will continue to monitor and progress outstanding environmental improvements, including painting and maintenance works identified through internal audits and quality reviews, to ensure the premises is maintained in a good state of repair and continues to meet residents' needs. 30/11/2026 Governance oversight of premises-related actions will be maintained through the Quality Enhancement Action Plan and regular management review meetings to ensure timely completion of all identified improvements 30/09/2026	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The registered provider has secured funding from the HSE and appointed a Design Team to progress the outstanding fire safety works relating to the compartmentalisation of the attic space. Quotes for the required compartmentalisation works have been requested and, following review and appointment of a contractor, the works will be completed in line with the fire safety review recommendations.	

Fire doors identified through internal inspections as requiring repair or adjustment will be reviewed and remedial works completed to ensure all fire containment measures remain fully effective. 31/08/2026

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/01/2027
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/11/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/11/2026
Regulation 17(7)	The registered provider shall	Not Compliant	Orange	31/01/2026

	make provision for the matters set out in Schedule 6.			
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	30/11/2026
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Substantially Compliant	Yellow	31/01/2027
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/08/2026
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	Not Compliant	Orange	19/05/2026

	allegation, 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	19/05/2026
Regulation 34(1)(b)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall make each resident and their family aware of the complaints procedure as soon as is practicable after admission.	Substantially Compliant	Yellow	03/06/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of	Substantially Compliant	Yellow	03/06/2026

	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.			