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:	Gort Na Mara
Name of provider:	St John of God Community Services CLG
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	08 April 2026
Centre ID:	OSV-0003645
Fieldwork ID:	MON-0041263

About the designated centre

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

This is a centre providing full-time residential services to three adults with disabilities. It comprises three small terraced bungalows .The buildings are located in the north east of the country and are near several towns and villages. Where required, transport is provided to residents for ease of access to community-based amenities such as shopping centres, pubs, hotels, hairdressers, and barbers. Each resident has their own bedroom, decorated to their style and preference. The bungalows comprise two bedrooms, a sitting room/dining room (with a small kitchen area), and a bathroom. The centre is staffed on a 24/7 basis by a person in charge, a clinical nurse manager I (CNM I), a team of staff nurses, and a team of healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 8 April 2026	09:45hrs to 16:25hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

The purpose of this announced inspection was to inform a decision on the provider's recent application to renew the registration of the designated centre. The previous inspection in October 2025, found high levels of compliance. This inspection was therefore undertaken to follow up on those findings and assess the actions taken by the provider to address the identified issues had brought about improvements for residents and improved compliance with the regulations.

Overall, residents living in this centre were supported to live meaningful and individualised lives, with good opportunities for independence, community engagement, and maintaining relationships. Residents appeared comfortable in their homes, familiar with their routines, and supported by staff who knew their preferences well. Interactions observed throughout the inspection were respectful and person-centred. While residents' day-to-day experiences were largely positive, some aspects of service delivery, in particular, financial practices, had the potential to impact on residents' lived experience and required further review.

The centre comprises three neighbouring single-occupancy houses situated within a residential estate in Co. Louth. Each home was observed to be well maintained, with appropriate outdoor space and parking facilities. The overall atmosphere within the centre was calm and homely.

During the inspection, the inspector met with all three residents. One resident returned home with their staff member and engaged briefly with the inspector. The resident demonstrated a clear preference for familiar staff, seeking reassurance and cues during the interaction, which reflected a consistent and supportive approach from staff in line with their assessed needs. A second resident was resting at the time of inspection and chose not to engage with the inspector, as they were feeling unsettled. This choice was respected, and the resident remained supported in a manner that prioritised their comfort and wellbeing.

The third resident was highly engaged during the inspection and invited the inspector to view their home. They shared a folder outlining their achievements and recent activities and spoke positively about their daily life. The resident demonstrated a good awareness of their routine, including a visual staff roster, and was observed preparing to go out. Interactions between this resident and staff were warm and familiar, reflecting a positive and respectful relationship.

Residents were supported to engage in a range of meaningful activities in line with their interests and preferences. One resident was actively engaged in the assisted decision-making process and maintained a varied routine, including attending cafés, horse riding, walking dogs from a rescue centre, and keeping up to date with current affairs. Another resident spoke about their interests and future plans,

including leisure activities such as golf, attending day services, and home decoration.

There was good evidence that residents were supported to maintain relationships with friends and family, with natural supports actively encouraged. Staff were observed to support residents to remain connected to their local community, supported by the centre's location and access to local amenities

At the time of inspection, three vehicles were assigned to the centre; however, one vehicle had recently been out of service. Staff had advocated on behalf of the resident affected and had submitted a complaint regarding the impact of reduced transport availability. While alternative arrangements were implemented, this disruption had, at times, impacted on access to planned outings and contributed to increased frustration and behaviours of concern for one resident, indicating a direct impact on their quality of life. The provider had also implemented a protocol to manage any future disruptions to transport, with a focus on minimising impact on residents' routines and access to community activities.

It was found that some financial practices within the centre had the potential to impact on residents' lived experience. While improvements had been made since the previous inspection, including the reimbursement of previously identified inappropriate charges, the inspector found that some financial arrangements remained unclear and lacked consistency. For example, policy stated that residents were expected to contribute towards staff meals and refreshments during outings, and in some instances, costs were applied for items within their homes. These practices were not clearly outlined in policy, nor was there consistent evidence of consultation or informed consent from residents. Further improvements were required to ensure residents' financial autonomy and rights were fully safeguarded.

The next two sections of the report outline 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 care provided to the residents.

Capacity and capability

The findings of this inspection were that the designated centre was well managed on a day-to-day basis, with clear staffing arrangements, regular management oversight, and systems in place to monitor the quality and safety of care. The provider had also taken action to address a number of the financial concerns identified at the previous inspection.

However, while there was evidence of improved oversight, some financial practices remained insufficiently clear and were not fully supported by provider policy. In particular, arrangements relating to residents contributing towards staff meals and

refreshments on outings, and some costs associated with items within residents' homes, required further review. These findings demonstrated that governance systems had not yet fully assured that all financial arrangements were transparent, equitable, consistently applied, and aligned with residents' rights.

The centre was managed by a person in charge who held the required qualifications and experience. They were employed at clinical nurse manager 3 level and had responsibility for four designated centres. The person in charge was supported by a clinical nurse manager 1, who also had oversight responsibilities across the centres. Management systems included daily reports from each centre to the person in charge, supplemented by overnight reports completed by a night manager. Monthly centre meetings were also held to review operational matters and support communication across the staff team.

There were established governance arrangements to monitor the quality of care provided. Monthly centre meetings were chaired by the director of nursing, who was also the nominated person participating in management. These meetings incorporated oversight of key areas including safeguarding incidents, staff training, and supervision, with data collated and reviewed on a monthly basis.

The provider had taken steps to address the inappropriate use of a resident's personal funds to pay for flooring repair works within the centre, which had been identified at the previous inspection. This expenditure was inappropriate, as responsibility for the maintenance and repair of the premises rests with the provider. The full amount was refunded to the resident. A retrospective referral was also made to the organisation's Equality and Human Rights Committee to acknowledge the breach of the resident's rights. In addition, the provider outlined plans to review internal financial audit processes and associated templates to strengthen oversight and accountability in safeguarding residents' financial transactions.

These actions had resulted in some improved financial oversight within the centre. For example, it was identified through review that one resident had been charged an incorrect rental amount, resulting in an overpayment. This was subsequently rectified, with adjustments made to ensure the correct charge was applied going forward. However, further improvement was required to ensure that all financial practices were subject to adequate governance, policy guidance, and review.

The centre was appropriately staffed to meet the assessed needs of residents. There was a full complement of staff in place, comprising staff nurses and healthcare assistants. Each resident was supported by a consistent staff team, with staffing arrangements developed around residents' assessed needs, preferences, and compatibility with staff. Residents were supported on a one-to-one basis during the day and at night. The roster had also been amended to change handover times in response to the needs of one resident, demonstrating a responsive approach to staffing.

There was a complaints procedure in place and complaints were recorded and reviewed. The inspector found that complaints were used as a mechanism to advocate for residents and to identify areas requiring improvement. For example,

staff had submitted a complaint on behalf of one resident when a centre vehicle was unavailable and this had impacted on their access to planned outings. This demonstrated that staff were aware of the complaints process and used it to raise issues affecting residents' quality of life.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted a complete application to renew the registration of the designated centre. The application included all required documentation as set out in the regulations, including the prescribed forms, supporting statements, and relevant assurances.

Judgment: Compliant

Regulation 14: Persons in charge

The centre was managed by a person in charge who held the required qualifications and experience for the role. They were employed at Clinical Nurse Manager 3 (CNM3) level and had responsibility for four designated centres. They were supported in their role by a Clinical Nurse Manager 1 (CNM1), which supported the effective operational oversight of the centre.

Judgment: Compliant

Regulation 15: Staffing

There was a full complement of staff working in the centre, comprising four whole-time equivalent staff nurses and 9.5 healthcare assistants. Each resident was supported by a consistent staff team, arranged in line with their assessed needs, preferences, and compatibility. Staffing arrangements included one-to-one support for each resident, both during the day and at night. The staff roster had been adjusted to amend handover times in response to the specific needs of one resident, demonstrating a responsive and person-centred approach to staffing.

Judgment: Compliant

Regulation 23: Governance and management

The provider had management systems in place to ensure that the service provided to residents was monitored and reviewed. There was evidence of regular management oversight, including daily reporting arrangements, monthly centre meetings, six-monthly unannounced audits, and a quality enhancement plan to track actions arising from audits and previous inspection findings. These systems had supported improvements in financial oversight since the previous inspection.

However, the governance systems had not fully ensured that all financial practices in the centre were clearly defined, consistently applied, or adequately reviewed. While the provider had taken appropriate action in response to previously identified inappropriate charges, further gaps were identified during this inspection in relation to residents' contributions towards staff-related costs and items within their homes. The provider's systems required further improvement to ensure they provided adequate oversight of all financial arrangements affecting residents.

The inspector reviewed a sample of residents' contracts of care and associated financial assessments. These outlined that residents had previously contributed towards utility costs, with the provider covering the remaining balance. However, it was confirmed that this arrangement had been discontinued following the full implementation of the Residential Support Services Maintenance and Accommodation Contribution, which incorporates rent and utility costs within the overall contribution. A review of rent and household expenditure indicated that residents' contributions were, in general, within the prescribed limits for their accommodation.

However, some documentation had not been updated to reflect these revised arrangements. This reduced clarity and transparency for residents and their representatives regarding current financial arrangements. In addition, it was documented that residents were required to contribute a small amount of money towards staff meals when on outings.

The provider's financial policy for managing residents' finances dated March 2026 did not provide sufficient clarity on what constituted reasonable or appropriate charges for residents. The practice of charging residents for staff meals and refreshments was not underpinned by provider policy. While this practice was reported to be common within the wider region, it was not consistently applied across the organisation. Staff spoken with also expressed discomfort with this practice.

Given the potential cumulative impact on residents' personal finances, and the absence of clear oversight or formal review of these arrangements, the inspector was not assured that all financial practices were transparent, equitable, or aligned with residents' rights. This lack of clear guidance presented a risk of inconsistent practice and required review at provider level.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspector reviewed the information provided in the statement of purpose dated November 2025 and found that it accurately reflected the service delivered in the centre, including details of the premises, staffing arrangements, and governance structures.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear and accessible complaints procedure in place in the centre. Residents were supported to raise concerns or make complaints, and information on how to do so was available in an appropriate and accessible format.

Records showed that complaints were monitored and reviewed as part of governance systems within the centre. One complaint relating to transport issues within the centre had led to changes in practice and service delivery.

Overall, the inspector was satisfied that there were effective systems in place to manage complaints and that residents were supported to have their concerns heard and addressed.

Judgment: Compliant

Regulation 4: Written policies and procedures

The inspector reviewed a sample of 12 policies and procedures during the inspection. While some policies appeared out of date on the electronic folder, the inspector was informed that updated versions were in place. Overall, the policies reviewed were found to be sufficiently detailed to guide staff practice and support the delivery of care in the centre.

Matters relating to the financial policy are discussed further under Regulation 23: Governance and Management.

Judgment: Compliant

Quality and safety

Residents were supported to enjoy a good quality of life, with access to meaningful activities, community participation, family contact, and individualised routines. They lived in single-occupancy homes that reflected their preferences. However, further improvement was required in relation to healthcare record oversight and financial safeguarding.

The inspector found that residents were supported to engage in a wide range of meaningful activities that reflected their individual interests, preferences, and personal goals. Evidence reviewed, including speaking with residents and staff, the centre's annual review and residents' personal plans, demonstrated that residents had opportunities for social inclusion, recreation, and personal development.

While action had been taken following the previous inspection, including reimbursement of inappropriate expenditure and referral to the organisation's Equality and Human Rights Committee, further areas for improvement were identified during this inspection.

Residents were supported to access appropriate healthcare services, and staff demonstrated good knowledge of residents' healthcare needs. Healthcare plans and protocols were in place and included guidance on residents' decision-making, consent, will and preferences. However, improvements were required in the oversight of healthcare records, including the monitoring and follow-up of blood test results and ensuring that healthcare documentation was consistently complete and up to date.

Regulation 13: General welfare and development

Residents had participated in a variety of activities both within their local community and further afield. These included attending concerts and tribute shows, sporting events such as the Leinster football final, religious services and social outings such as afternoon tea and sunset cruises. Residents were also supported to maintain important family connections, including attending family events such as weddings and visiting family members regularly.

There was evidence of residents engaging in activities that promoted independence and personal fulfilment. For example, one resident had undertaken home improvement projects, while another was actively involved in gardening. Opportunities for relaxation and self-care were also supported, with residents accessing services such as hair and nail appointments and sensory-based activities.

Residents were supported to access holidays and overnight stays, including trips within Ireland, which contributed to their overall wellbeing and quality of life. In

addition, residents were facilitated to pursue personal interests and hobbies, such as attending local clubs and engaging in community-based activities.

Judgment: Compliant

Regulation 6: Health care

Overall, there were systems in place to support residents' healthcare needs. Residents had access to a range of appropriate healthcare professionals, and staff demonstrated a good understanding of residents' assessed health needs. Care plans and healthcare protocols were in place to guide practice, including clear information on how residents made decisions, their will and preferences, and how consent was obtained.

However, improvements were required in the oversight of healthcare records. The inspector identified gaps in the monitoring and recording of blood test results, including a lack of clear evidence that anomalies were consistently identified, escalated, and followed up appropriately. Some gaps were also noted in healthcare documentation with conflicting information between assessments and healthcare action plans.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that governance arrangements to ensure residents were protected from inappropriate financial practices required further review, in line with the findings of the previous inspection.

While the provider had taken action to address a significant financial issue identified previously, whereby a resident had inappropriately funded repair works within their home, and had ensured reimbursement and referral to the organisation's Equality and Human Rights Committee, these improvements had not been fully embedded in practice. Although enhanced financial oversight mechanisms, including audits and reviews, had been introduced, gaps remained in the consistent application of safeguards.

During this inspection, the inspector identified practices that were not underpinned by clear policy or organisational guidance. In particular, residents were required to contribute towards staff meals and refreshments when on outings. This practice was not referenced in the provider's financial policy, and there was no evidence of consultation with residents or documented consent. Staff also reported discomfort with this arrangement. Furthermore, there were examples of residents being

charged for items within their homes, such as fixed furnishings, without clear guidance as to whether such costs were appropriate.

While no immediate safeguarding incidents were identified at the time of inspection, the absence of clear, consistent, and transparent financial practices posed a potential risk to residents. The cumulative financial impact of these practices, combined with insufficient oversight and lack of clear policy direction, meant that the provider could not fully demonstrate that residents were protected from all forms of financial abuse or inappropriate financial arrangements.

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
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Gort Na Mara OSV-0003645

Inspection ID: MON-0041263

Date of inspection: 08/04/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• A Standard Operating procedure is being developed to guide practice in the designated center, it will specifically cover residents spending relating to fixtures and furnishings, use of loyalty cards and any staff related costs.

• The Finance policy indicating the practice of residents contributing to staff related costs has been reviewed and amended to move this section

• A review has been completed in the Designated Centre which indicated that no residents have been contributing to staff meals or drinks during outings in the Designated Centre.

• Each resident has a comprehensive Financial Passport which has been reviewed and updated in line with their individual financial preferences.

• There is an audit schedule in place in Designated Centre to ensure appropriate governance and oversight of residents' finances.

• Person In Charge completes 'spot checks at a minimum of quarterly to ensure robust oversight

• Finances are discussed with family when there is a personal expenditure amounting to more than five hundred euro.

• Keyworker meetings now reflect where the residents are consulted in relation to their financial decision making, it is also documented where capacity building has been supported

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• All blood results have been reviewed with their GP as appropriate.

• The residents' care plans have been updated to ensure clear guidance in managing health conditions is explicitly stated

Regulation 8: Protection	Not Compliant

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

• There is an audit schedule in place in Designated Centre to ensure appropriate governance and oversight of residents' finances

• Person In Charge completes 'spot checks at a minimum of quarterly to ensure robust oversight

• Finances are discussed with family when there is a personal expenditure amounting to more than five hundred euro

• A Standard Operating procedure is being developed to guide practice in the designated center, it will specifically cover residents spending relating to fixtures and furnishings, use of loyalty cards and any staff related costs

• The Finance policy indicating the practice of residents contributing to staff related costs has been reviewed and amended to move this section

• A review has been completed in the Designated Centre which indicates that no residents have been contributing to staff meals or drinks during outings

• Keyworker meetings now reflect where the residents are consulted in relation to their financial decision making, it is also documented where capacity building has been supported

• Each resident has a comprehensive Financial Passport which has been reviewed and updated in line with their individual financial preferences

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	01/11/2026
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	10/04/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	01/11/2026