



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

Issued by the Chief Inspector

Name of designated centre:	DC8
Name of provider:	St John of God Community Services CLG
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	03 June 2026
Centre ID:	OSV-0003788
Fieldwork ID:	MON-0044519

About the designated centre

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

St John of God Kildare Services DC 8 is a large single story building that has been renovated to provide care for up to 14 residents, on its' own site on the outskirts of a large town in Co. Kildare. The centre is divided into two sections supporting both males and females who present with physical and intellectual disabilities. In addition, seven placements are dedicated to residents with a diagnosis of dementia. These residents have identified clinical and medical needs, for example, psychiatry and psychology input available to them through the clinical team. Residents are supported by nursing staff, health care assistants and social care workers. Residents have access to a large sensory garden on its grounds. The centre is accessible to local towns, shopping, public transport and community facilities. The centre also has replicated recreation spaces for residents to enjoy, including a salon, a cinema room, and a cafe. The person in charge is supported by two clinical nurse managers and a social care leader.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14
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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 3 June 2026	09:30hrs to 17:45hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

This was an unannounced inspection and the purpose of the inspection was to review the centre's compliance with specific regulations. Overall inspection findings indicated that residents were very happy and safe living in their home. There were good levels of compliance found with the regulations reviewed. Some minor areas requiring improvements were identified in areas such as staff training, policies and procedures, resident consultation and fire safety checks and these will be discussed further in the report.

There were 14 residents with moderate to high support needs living in the centre on the day of inspection and no vacancies. The inspector had the opportunity to meet with all 14 residents throughout the inspection as they went about their lives and normal daily routines.

The inspector started the inspection day with a walk around the centre and this was facilitated by the person in charge. The centre is a large single storey building situated on the outskirts of a large town in Co. Kildare. One section of the centre was dedicated to providing tailored residential support to individuals with both an intellectual disability and a diagnosis of dementia. Sections of this area had specialised rooms specifically designed for residents with dementia. These included a beauty salon where residents could have hair, hands, feet and aromatherapy treatments in a calm environment. Another room replicated a cinema room with red velvet curtains and popcorn-making facilities and had a large projector to show films. And a third room was designed as a café, complete with tea and coffee-making facilities for residents to enjoy meetings with visitors. The café also had a functioning kitchen that allowed residents to take part in cooking and baking activities. The inspector noted residents using these rooms throughout the day with support from staff. Bathrooms in this area of the building had also been specifically designed for people with dementia and high support needs and they had features such as brightly coloured door frames, grab rails, adapted toilet seats and signs. Residents' bedrooms were thoughtfully decorated to reflect their unique preferences and personalities.

The inspector met with some residents as they were having their breakfast on the morning of the inspection during the walk around the centre. Residents appeared very comfortable and happy in their home. Staff supporting them appeared familiar with their individual needs and preferences and kind interactions were observed between staff and residents.

The second part of the building accommodated another seven residents with varying physical and intellectual disabilities. The profile of residents living here were also an aging population and the environment had also been tailored to meet their needs with ample space, individualised bedrooms, communal areas and quiet spaces. Residents also had a large sensory garden in their home. This was wheelchair

accessible and well maintained. This included an outdoor seating and barbecue area where residents had been enjoying sitting out in the sunshine in recent weeks. The centre also had an internal garden, and this required some maintenance on the day of inspection. The centre had three well-equipped kitchens where food could be stored and prepared in hygienic conditions. There were some parts of the building that did not fall within the floor plans of the designated centre and were unused or were only used as administration and office space.

The inspection was facilitated by the person in charge and they were present throughout the inspection day. The person in charge was also supported by a residential co-ordinator, two CNM1's and a social care leader. The centre's staff team was a mix of nursing staff, social care workers and healthcare assistants. The centre had its full staff complement in place on the day of inspection and there were no vacancies. Staffing numbers were in line with residents' assessed individualised needs.

Activation for residents was varied and tailored to suit some residents advanced dementia and high supports needs. Some residents were retired and did not attend any day services while some left the centre regularly for activation and day services. Residents all had activation planners in place and residents who stayed in their home on a daily basis enjoyed activities with staff such as music, walks, beauty therapies, reflexology and massage. Residents could also enjoy their in-house cinema room, beauty salon and café. Communal areas had arts and crafts facilities, assistive technology, sensory items, musical equipment and memory aids. Some residents had holidays planned for later in the year. All residents appeared very content in their home. Residents could not verbally communicate their views with the inspector, however vocalisations, facial expressions and relaxed demeanors indicated that they were happy and comfortable in their home.

Overall the inspector found that the centre was meeting the specific care needs of the residents living in DC8. Residents appeared happy and content living in their home and they were supported by a staff team that were familiar with their health and social needs and preferences.

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

This was an unannounced inspection. The provider demonstrated the capacity and capability to provide a safe and effective service to the residents living in DC8 and the inspector found clear and robust management and oversight systems in place. There were appropriate staffing numbers and skill mixes in place in the centre to meet the residents' needs. Staff had completed training in mandatory areas and a

schedule was in place to ensure that all staff were regularly supervised. Some issues were noted with the centres Statement of Purpose, as noted further under Regulation 3.

Regulation 15: Staffing

The inspector reviewed staffing arrangements in place to support the residents. Overall it was found that there were sufficient staff numbers and a skill mix in place to meet the individualised needs of the residents. The staff team comprised of nursing staff, social care workers and healthcare assistants. There were no staff vacancies on the day of inspection and the centre had its full staff complement in place. The inspector completed a review of three months of the staff rota and it was found that this was well maintained and reflective of staff on duty. Staff grades were clearly noted on the rota. The centre had agency staff and relief staff available to fill shifts during times of staff leave. There was minimal use of unfamiliar staff in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

There was a program of staff training in place and the inspector completed a review of staff training records. Staff were completing training in mandatory areas such as manual handling, safeguarding, fire safety, children's first, behavior management, dysphagia. Training needs were regularly reviewed and refresher training was scheduled for staff when required. Following a review of staff training records it was found that while the majority of staff had up-to-date mandatory training, two staff were due behavior management training and one staff member was due fire safety training.

Schedules were in place to ensure that all staff experienced regular one-to-one supervision with a line manager and all staff were receiving supervision twice per year. A probation schedule was also in place for any new staff working in the centre

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear management structure in the centre which was outlined in the centre's statement of purpose. There was a person in charge who facilitated the

inspection day and they were regularly present in the designated centre. They were supported by a residential co-ordinator, two CNM1's and a social care leader.

There were clear oversight systems in place, such as regular audits and reviews, and these were identifying areas in need of improvements in the service.

Management were completing six-monthly unannounced inspections in the centre and a report from the most previous audit in May 2026 was available. The inspector found that this was appropriately self-identifying areas in need of improvements and had clear action plans and timelines for completion identified.

An annual review of the care and support provided in 2025 had been completed. The person in charge communicated that residents and their families were consulted regarding their views and satisfaction with the service provided through phone calls. However, there was no record maintained of these consultations and consultation with the residents was not completed in a manner that was accessible to residents and in line with their communication needs.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was available in the centre and was reviewed by the inspector. It contained information set out in Schedule 1 such as the registration details, support needs in the centre and staffing arrangements. However, the inspector noted that the purpose of all rooms did not match what was recorded in the statement of purpose. For example one room identified as a living room was being used as a storage room for wheelchairs. Another room identified as a kitchen and dining room on the floor plans was not being used as such, and was in the process of being converted into a clinical room. This was not in line with Condition 1 of the centre's registration certificate and an application to vary was required to accurately reflect these changes on the centre conditions of registration. The statement of purpose and centre floor plans required review to ensure that these changes were accurately reflected.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider had ensured that all schedule 5 policies were in place as required by Regulation 4. These were made available to staff. Following a review of these, it was found that four of the Schedule 5 policies had not been reviewed within a three year

time period and required review. The system and process for reviewing policies and implementing updated policies required attention by the provider.

Judgment: Not compliant

Quality and safety

Overall, it was found that the provider was endeavouring to provide a safe and effective service to the residents living in the designated centre. The inspector found that quality assurance methods were ensuring that the centre had appropriate risk management and fire safety arrangements in place, although some improvement was needed in the routine monitoring of fire safety to ensure it occurred as required. Management were ensuring regular monitoring and oversight of the service provided.

Residents presenting with healthcare needs such as dementia were supported to appropriately manage their health and had good access to multi-disciplinary supports when required. All residents had up-to-date assessments of need and personal plans and these were regularly reviewed and updated. Residents were safeguarded in the centre. There were no open safeguarding concerns in the centre on the day of inspection

Regulation 10: Communication

A high number of residents did not communicate verbally and presented with alternative communication needs. Residents had communication support plans in place and these were found to be individualised and reflective of residents' personal communication methods such as vocalisations, gestures, facial expressions and body language. Residents had access to speech and language therapy within the service and some were regularly reviewed for support with communication needs and feeding, eating and drinking (FED's) needs. The inspector noted picture versions of the centre's daily menu prominently displayed in the centre kitchen and staff communicated that residents were consulted daily with pictures regarding their meal choices. Staff spoken with appeared to be very familiar with residents individual communication methods.

It was noted that the annual consultation with residents regarding their satisfaction with the service provided was not available to residents in an accessible version and this is detailed further under Regulation 23.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider's risk management policy was found to meet regulatory requirements and was subject to regular review. The centre's risk register and residents' individual risk assessments were reviewed and these were found to be reflective of the presenting risks and incidents occurring in the centre. Centre specific environmental risks had been considered and mitigating measures had been implemented when required.

The inspector reviewed a sample of the centre accident and incident log. This was well maintained. Overall, there was a low level of adverse events occurring in the centre. All incident reports had been reviewed by the senior management team and appropriate action was taken when required such as referrals, reviews and implementing mitigating risk measures.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector found that the provider had ensured there were appropriate fire safety systems in the centre. A walk around the centre found that there were appropriate detection systems, emergency lighting, containment and fire fighting equipment. These were all serviced and checked regularly by a qualified fire safety specialist. All fire doors in the centre were found to be in working order.

The evacuation procedures were prominently displayed in the designated centre. Staff and residents were completing regular fire drill evacuations. These simulated both day and night time conditions and demonstrated that the centre could be evacuated in an efficient manner in the event of a fire with minimum staffing levels. All residents had personal emergency evacuation plans (PEEP's). These included residents' pictures and individual support levels required in the event of an emergency evacuation.

Regular fire safety checks were being completed by staff in the centre. These included checks on the centres fire safety panel and exit routes. The inspector reviewed fire safety check records since November 2025 and it was found that there were 25 incidents where staff had not signed that safety checks had been completed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents all had individualised assessments of need and personal plans in place to support their health, social and personal care needs. Plans appeared to be guiding staff practice in the centre. Residents all experienced an annual review of their care and this was reported as an opportunity to review personal goals and plans for the year ahead. Some residents had plans to meet family and friends, go on holidays, develop their garden or go to a soccer match.

Activation for residents was varied and tailored to suit some residents with advanced dementia and high support needs. Some residents were retired and did not attend any day services while some left the centre regularly for activation and day services. Residents all had activation planners in place and residents who stayed in their home on a daily basis enjoyed activities with staff such as music, walks, beauty therapies, reflexology and massage. Residents could also enjoy their in-house cinema room, beauty salon and café. Communal areas had arts and crafts facilities, assistive technology, sensory items, musical equipment and memory aids.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to manage their health in the centre. Residents all experienced annual assessments of their health needs and further supports were implemented when required. All residents had hospital passports in place for use in the event of transfer to an acute healthcare facility. Some residents had a diagnosis of dementia and they had specific dementia care plans in place which were regularly reviewed. Residents who presented with ongoing healthcare needs had access to nurse support within the centre. Residents presenting with skin vulnerabilities and nutritional risks were regularly assessed and reviewed and supports put in place when required.

End of Life care plans had been developed for some residents and these were person-centred and individualised. Plans considered residents' comfort preferences, pastoral care, pain management, and feeding, eating and drinking needs. Residents had access to a range of multi-disciplinary supports such as speech and language therapy, occupational therapy, physiotherapy, and a dementia clinical nurse manager and residents were regularly reviewed with their General Practitioner (GP).

The majority of residents required support from adaptive equipment such as wheelchairs, comfort chairs, hoists, pressure relieving mattresses and adaptive bathrooms and showers. These were all provided within the service and clean and well maintained.

Judgment: Compliant

Regulation 7: Positive behavioural support

Overall, there was a low requirement for positive behavioural support to help residents manage behaviours of concern. When required, residents had behavioural support plans. Residents had access to a dementia clinical nurse manager who supported the development of care and support plans for people with dementia and related care needs.

There were some restrictive practices in use and these were relative to identified risks to the residents. The centre maintained a restrictive practice register and this was reviewed regularly and relevant restrictive practices were approved by the service occupational therapist. The restrictive practices in the centre had corresponding risk assessments which detailed rationale for their use. Two staff members required up-to-date training in behaviour management and this is actioned under Regulation 16.

Judgment: Compliant

Regulation 8: Protection

Residents were safeguarded in the centre. There were no open safeguarding concerns in the centre on the day of inspection. Residents were living together compatibly and safeguarding incidents were minimal. The service had a designated officer for managing any safeguarding concerns. Any safeguarding concerns were treated in a serious and timely manner and in line with national policy. All staff had training in the safeguarding and protection of vulnerable adults and residents had intimate care plans in place to support them safely with personal care.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for DC8 OSV-0003788

Inspection ID: MON-0044519

Date of inspection: 03/06/2026

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge will ensure that all staff mandatory training is completed. 2 x Staff behaviour management training has been completed, and 1 x Staff Fire Safety training is scheduled and will be completed by 31/08/2026.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A comprehensive review of the consultation process used to obtain the views of residents, and their families will be completed in advance of the 2026 Annual Review of the Quality and Safety of Care and Support. This review will ensure that consultation is conducted in a manner that is accessible to all residents, taking account of their individual communication needs. It will also establish a clear process for documenting and maintaining records of all consultations with residents and their families, ensuring that their feedback is captured and informs the annual review process.	
Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Statement of Purpose and associated floor plans will be reviewed and updated to accurately reflect the current layout and purpose of all rooms within the designated centre. An application to vary Condition 1 of the centre's registration, including updated Statement of Purpose and updated floor plans, will be submitted to the Authority to ensure that the conditions of registration accurately reflect the current layout of the centre.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The registered provider will continue to review and update policies required as per Schedule 5 of the Health Act. Two policies that were out of review date have been released and are available, the remaining two policies are scheduled for release in August and September.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The person in Charge will ensure that all Fire Safety Checks are completed as outlined in the SJOGCS Fire Safety Register. The Person in Charge has communicated to all staff via email to ensure all checks are completed, this action will be on the agenda and communicated at staff meetings. The centres daily allocation sheets have also been updated and responsibility for the checks has been assigned to the shift leader daily. The person in charge will monitor and sign off on the Fire Safety Register checks at the beginning of each week.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/08/2026
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/11/2026
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	29/06/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of	Not Compliant	Orange	31/08/2026

	purpose containing the information set out in Schedule 1.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/09/2026