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:	DC18
Name of provider:	St John of God Community Services CLG
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	11 June 2026
Centre ID:	OSV-0005814
Fieldwork ID:	MON-0045295

About the designated centre

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

Designated centre 18 is a community based residential service in Co. Kildare for a maximum of three residents with an intellectual disability where support is provided 24 hours 7days a week. Residents are supported by social care workers and care assistants. Residents are supported to attend a day service, if they so wish. However all opportunities for leisure and hobbies/interests that are available in the community are pursued, in line with the wishes and goals of residents. The designated centre is a dormer bungalow with two bedrooms located downstairs and a bedroom upstairs with an en-suite. There is an accessible bathroom on the ground floor. There is a combined kitchen and dining area and separate living room. Residents have access to a car and are supported by staff in order to access amenities and services as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Thursday 11 June 2026	09:30hrs to 16:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

This was an unannounced inspection completed for the purpose of monitoring the centre's overall compliance with specific regulations. In general the inspector found that while residents were happy living in the centre, a number of areas required improvements such as governance and management, care planning, behavioural support documentation, fire safety and contracts of care. These will be discussed further in the report.

There were two residents living in the centre on the day of inspection and one vacancy. The centre had no person in charge on the day of inspection. A senior nurse manager was contacted at the start of the inspection and they attended the centre later in the morning and facilitated the inspection day.

There was one resident present when the inspector arrived to the centre and two staff members. The inspector met with the staff and then the resident took the inspector by the hand to show them their room, where they had some sensory equipment and a guitar. The resident appeared happy in their personalised space with their sensory items. The resident did not communicate verbally but the inspector noted happy facial expressions. The resident appeared content getting ready for their day with support from staff.

The inspector completed a walk around the premises. In general, this was in a good state of repair and well maintained. The designated centre was a dormer bungalow with two bedrooms located downstairs and a bedroom upstairs with an en-suite. There was an accessible bathroom on the ground floor. There was a combined kitchen and dining area and separate living room. Residents each had their own bedrooms on the ground floor and these had been decorated in line with their preferences. One resident had recently moved to the centre and had decorated their room with colours dedicated to their favourite soccer team.

The staff team was a mix of nursing staff and support workers. There were some staff vacancies on the day of inspection. The inspector found that the centre was managing these vacancies well with regular staff and regular relief staff filling vacant shifts. Staff met with on the day of inspection were found to be knowledgeable regarding the residents and responsive to their needs and preferences.

Residents enjoyed regular activation and were supported to access their circle of support and wider community. Both residents had experienced personal planning meetings and had set personalised goals for the year ahead, including goals to go on day trips, complete works to their garden, holidays and develop some independent living skills. Both residents attended day services and were out at day services on the day of inspection. One resident told the inspector about their job, and they attended this by accessing public transport independently. One resident

had a picture planner board in place with pictures of the resort they were going to for an upcoming holiday.

Overall both residents appeared very happy living in their home. Residents enjoyed regular activation, familiar staff and there were no safeguarding concerns. However, there were a number of areas that required improvements to promote higher levels of compliance with the regulations reviewed.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Some concerns were identified regarding the provider's capacity and capability in the day-to-day running of this centre. In particular there was no person in charge on the day of inspection. The provider was aware of this and had recruited someone to fill the position, however, they were not starting the position for another two weeks post the inspection date. The registered provider had ensured a clear management structure was in place despite this key gap. The provider's quality team were completing audits to review the quality and safety of the service being provided. A number of areas of non compliance were identified with the regulations reviewed on this inspection.

Regulation 14: Persons in charge

The centre had no person in charge on the day of inspection as required by Regulation 14. The provider had identified someone to fill this role, however they were not due to start in the centre for another two weeks after the inspection day. A senior nurse manager was allocated to manage the centre prior to the new person in charge commencing the role and they facilitated the inspection day.

Judgment: Not compliant

Regulation 15: Staffing

There was a staff team in place to support the residents. The staff team had received training to support them in their roles. The staff team comprised a mix of

nursing staff and support workers. There were some staff vacancies on the day of inspection. The inspector found that the centre was managing these vacancies well with core staff and regular relief staff filling vacant shifts. There was a staff rota in place and this was reflective of staffing numbers and staff working in the centre. Staff met with on the day of inspection were found to be knowledgeable regarding the residents and responsive to their needs and preferences.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector completed a review of staff training records and found that staff had access to appropriate training to support the residents in the designated centre such as fire safety, safeguarding and manual handling. Staff had completed all training identified as mandatory and had completed some training specific to the needs of residents. Staff completed refresher training in these areas when required.

The former person in charge was undertaking formal supervisions with staff throughout the year in line with the provider's policy, twice per year and these were found to have occurred in line with this schedule.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found some concerns regarding oversight systems in the centre, given the overall poor levels of compliance on the inspection in areas including care planning, behavioural support documentation, fire safety, policies and procedures and contracts of care.

An annual review of the service had been completed for 2025 and a six monthly unannounced visit had been completed by the service quality team in May 2026. In general. these were found to be comprehensive and identifying areas in need of improvements. However, a fire safety audit had been completed in the centre in March 2022. This had been completed by a fire safety specialist and had highlighted a number of actions to be completed. To date, the provider had failed to address these effectively in a timely manner.

As previously highlighted, the centre had no person in charge on the day of inspection as required by Regulation 14. Supervision of staff had been taking place regularly with the previous person in charge, however staff meetings were scheduled to take place fortnightly and meeting records indicated that these had only taken place twice in 2026 in February and April.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed residents' contracts of care and found that one resident did not have any contract on admission to the designated centre. The resident had been residing in the centre for 31 days on the inspection day.

Judgment: Not 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. One room identified as a bedroom was being used as the staff office and the room identified as an office on floor plans was used as a bedroom.

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

The inspector reviewed a number of areas to determine the quality and safety of the service being provided in the designated centre. This included reviewing the

premises, meeting with both residents, speaking with staff and management and reviewing documentation such as personal plans, daily notes, incident reports, risk management documentation and fire safety records. Overall it was found that while there were systems in place to review quality in the centre, some improvements were required to ensure the service provided was always safe. A number of concerns were noted under Regulation 28 Fire Precautions.

Regulation 17: Premises

In general the inspector found that the designated centre was well maintained, clean and designed and laid out to meet the residents assessed needs. The designated centre was a dormer bungalow with two bedrooms located downstairs and a bedroom upstairs with an en-suite. There was an accessible bathroom on the ground floor. There was a combined kitchen and dining area and separate living room. Residents each had their own bedrooms on the ground floor and these had been decorated in line with their preferences. One resident had recently moved to the centre and had decorated their room with colours dedicated to their favourite soccer team. The purpose of two rooms in the centre had been changed since the centres registration renewal and this is discussed further under regulation 3.

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. Appropriate action was taken following any adverse incidents such as referrals, reviews and implementing mitigating risk measures. Residents had individual environmental safety checklists and manual handling protocols.

Judgment: Compliant

Regulation 28: Fire precautions

A number of areas of concerns were noted in the area of fire safety in the designated centre.

A fire safety audit had been completed in the centre in March 2022. This had been completed by a fire safety specialist and had highlighted a number of actions to be completed by the provider in the centre. This included:

- The development of a "zone" chart in the centre as zones were currently not clear. For example if the centres fire panel indicated there was a fire risk in Zone 1, staff were unable to determine what part of the centre this was.
- Emergency exit signage required at two of the centre's emergency exit routes.
- Emergency lighting required in one of the centre's main exit routes.

The provider had not addressed these issues since their identification in 2022 and highlighted funding as a barrier to a addressing these issues.

One resident did not have a personal emergency evacuation plan (PEEP) and had not taken part in an emergency evacuation drill since their admission to the centre 31 days prior to the inspection day. Both of these areas had been addressed by the close of the inspection day. A PEEP was developed for the resident and the inspector observed the resident partaking in a drill upon their return to the centre and this was carried our in an efficient manner with minimal staff support.

Regular fire safety checks were being completed by staff in the centre. These included checks on the centre's fire safety panel and exit routes. The inspector reviewed fire safety check records from March to June 2026 and it was found that there were 10 incidents where staff had not signed that safety checks had been completed.

Procedures to be following in the event of a fire, such as exit routes, were not available and not prominently displayed in the designated centre on the day of inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The designated centre was suitable to meet the needs of the residents. Residents were supported to meet their social care needs and goals. Residents enjoyed regular activation and were supported to access their circle of support and wider community. Both residents had experienced personal planning meetings and had set personalised goals for the year ahead. including goals to go on day trips, complete works to their garden, holidays and develop some independent living skills. Both

residents attended day services and were out at day services on the day of inspection.

However, the inspector reviewed assessments of need and personal plans in place and found that one resident who had recently been admitted to the centre had no personal plan in place. Regulation 5 required that a personal plan is prepared no later than 28 days after a resident is admitted to a designated centre. The resident had been residing in the centre for 31 days on the day of inspection. The resident had experienced an assessment prior to their admission. The second resident had an assessment of need and personal plan in place and these were found to be reflective of their current needs. Residents both had hospital passports in place where healthcare needs had been assessed.

Judgment: Not compliant

Regulation 7: Positive behavioural support

One resident presented with some behavioural support needs and required a positive behavioural support plan. The inspector reviewed the plan in place and found that it had not been reviewed or updated since 2023. It was noted that there was an open referral to the service behavioural specialist for review of this plan.

There were some restrictive practices in use in the centre. The provider had a restrictive practice committee and any use of a restrictive practice was approved and reviewed regularly with the committee. Any use of restrictive practices had been notified to the Chief inspector on a quarterly basis. However, one restrictive practice in use had not been detailed in the associated resident behavioural support plan. This was not found to be having a negative impact on the resident and the issue had been self-identified by the provider for review with the behavioural specialist.

Judgment: Substantially compliant

Regulation 8: Protection

There were no open safeguarding concerns in the centre on the day of inspection and residents were found to be safeguarded. There had been no peer to peer safeguarding concerns since the residents had been living together in the previous four weeks. 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. One resident had an intimate care plan in place and

the second resident did not yet have a personal plan developed, as detailed further under Regulation 5.
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	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for DC18 OSV-0005814

Inspection ID: MON-0045295

Date of inspection: 11/06/2026

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • The registered provider has appointed a Person in Charge. 06/07/2026	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Registered Provider will review governance and oversight arrangements The Quality Improvement Plan will be addressed to identify and monitor compliance deficits. 30/09/2026 • The Person in Charge will ensure oversight and continuous monitoring of care planning, behavioural support documentation, fire safety, policies and procedures, and contracts of care. 30/09/2026 • The Registered Provider and the Person in Charge will ensure a comprehensive review of the centre's governance and oversight arrangements. 30/09/2026 • The status of all outstanding audit actions will be reviewed monthly by the PIC and discussed at management and governance meetings. Any delays or barriers to completion will be identified and addressed promptly to ensure actions are progressed and closed out effectively. 30/09/2026 • The fire safety audit has been reviewed by the Health and Safety Officer. An action plan will be developed to address outstanding recommendations identified through the audit. 30/08/2026	

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• The Person in Charge will ensure that all resident's have a contract of care. 30/08/2026

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Following the inspection, an application to vary the centre's registration was submitted to reflect the current use of rooms within the designated centre. The Statement of Purpose and accompanying floor plans have been updated to accurately identify the room being used as a staff office and the room being used as a resident bedroom. Systems have been implemented to ensure that any future changes to the function of rooms are reviewed in advance and appropriately reflected in the Statement of Purpose and registration documentation to ensure ongoing compliance with regulatory requirements. 14/07/2026

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 provider is currently progressing the review of the outstanding policies to ensure they reflect current legislation, regulations, and organisational practices. The policy management system is also being strengthened through improved tracking and oversight arrangements to ensure all policies are reviewed within required timeframes going forward and that updated policies are communicated effectively to staff upon completion. 30/11/2026

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• The fire safety audit has been reviewed by the Health and Safety Officer. An action plan will be developed to address outstanding recommendations identified through the audit. 30/08/2026
• The Person in Charge will increase oversight of fire safety records through regular audits to ensure checks are completed and signed as required. Any omissions identified will be followed up promptly with staff to support compliance and accountability 30/08/2026

• Fire action notices and evacuation route information have been displayed prominently throughout the designated centre to ensure they are readily available to residents, staff, and visitors. The Person in Charge will ensure ongoing monitoring will be undertaken.30/07/2026

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The Person in Charge has ensured that the resident referred to in the report has a comprehensive assessment in place and a corresponding personal plan that accurately reflects his assessed needs, preferences, and supports required. 30/07/2026

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The resident referred to in the report has been assessed by an appropriately qualified Behaviour Specialist. Following this assessment, a Positive Behaviour Support Plan has

been developed and implemented to guide staff in supporting the resident in a consistent and person-centred manner. The plan clearly outlines the resident's assessed support needs, proactive strategies, and the restrictive practice required to ensure the resident's safety. Staff have been informed of the updated plan and ongoing review arrangements are in place to ensure it remains current, effective, and reflective of the resident's needs.
15/07/2026

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 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Orange	06/07/2026
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	30/09/2026
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	30/08/2026

Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/07/2026
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/08/2026
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	30/07/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	14/07/2026
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	30/11/2026

Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/07/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	15/07/2026