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:	North Kildare
Name of provider:	Gheel Autism Services CLG
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	04 December 2025
Centre ID:	OSV-0007789
Fieldwork ID:	MON-0043353

About the designated centre

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

This centre comprises three houses. The centre aims to provide a residential service for a maximum of six residents with intellectual disability and or Autism, two residents in each of the houses. Each of the three houses are located within the same geographical area but a relatively short drive away from each other and from local amenities. Two of the houses were located on their own grounds in a rural setting, while the third house, a two storey detached house was located in a quiet residential estate in a town. Each of the houses had suitable bathroom facilities, kitchen come dining room, living area, individual bedrooms for residents and laundry facilities. Each of the three houses had a nice sized garden for residents use. The residents in each of the houses were supported by social care workers, a location manager and the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 4 December 2025	10:17hrs to 17:45hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

The inspector observed warm, kind, dignified and respectful interactions with residents throughout the day by staff and management. Staff and management were knowledgeable about the residents' needs, and it was clear that they promoted and respected the rights and choices of residents living in the centre. Residents were supported to enjoy a good quality of care in this centre. While a good quality service was being provided, some improvements were required to ensure safe care and that oversight and management systems in place were fully effective to drive quality improvement. A review of the statement of purpose was also required to ensure that it accurately reflected the service being provided. Further improvements were also required in record management, policies and procedures and premises, which will be detailed in the report below.

The designated centre comprises three houses located in Kildare, a short drive away from each other. It is registered to accommodate a maximum of six residents, with a maximum of two residents in each house. On the day of inspection, there were four residents accommodated in the designated centre. One house had two residents living there and the remaining houses had one resident residing in each. One of the houses was used as a respite service, with the same resident attending the centre Monday to Friday every week.

During the inspection, the inspector visited two of the three houses. This was due to delays in the inspector being able to access the second house while awaiting the person in charge to arrive and further delays throughout the day in accessing documents. When the inspector arrived at the first house, which was located in a rural area, they were greeted by staff and the resident who welcomed them into the house. The resident brought the inspector to see their bedroom and walk-in wardrobe. The staff present showed the inspector around the rest of the house, which was homely with ample space for the resident both internally and externally. The house was a two-storey detached building with a large open garden, an activity room, sitting room, kitchen/dining room, staff sleepover rooms and an office. The resident went out into the community for a drive and the inspector left to view the second house which formed the designated centre.

The second house was located in a rural area in a cul-de-sac, near local amenities and had two residents residing in it. On arrival to the centre, residents and staff were out at activities. At the request of the inspector, the person in charge and social care manager attended the centre to facilitate the inspection. This was a two-storey detached house with a small front and rear garden area, with a 'garden building' in the back garden. The inspector was informed that this was used to support a resident with their independent living skills. It had a bright open room with a television, sofa, gym equipment, games, arts and crafts materials and an adjacent storage room. The inspector observed a resident use this as their preferred space throughout the inspection, however, this was not on the centre floor plans

registered as part of the designated centre. The house also consisted of a kitchen-dining room, sitting room on the ground floor and an activity room on the first floor. The house was very pleasantly decorated with a homely atmosphere.

Generally, the designated centre was maintained to a high standard with some areas of wear and tear. The centre was generally clean and tidy, however, some improvements were required to ensure areas like the bathrooms were effectively cleaned.

Where two residents were living together, staff reported that they got along very well and enjoyed doing activities together, while also enjoying doing their own activities too. Recently, both residents had joined a local gym and were attending sessions with a personal trainer. One resident was also attending a dietitian to support them with healthy eating. Staff spoken with were very familiar with both residents' nutrition needs and supported the residents to have fresh, nutritious meals cooked for them each day. The inspector observed staff making lunch and dinner for the residents and saw that dietitian snack and food swap recommendations were being implemented to meet the residents' needs.

On the day of inspection, residents had attended the gym with staff to use the hot tub and swimming pool. Later in the afternoon they drove to a nearby park and took a walk. Staff were limited in the activities they could do on the day as they did not have a full complement of staff which was assessed as required to meet the residents' needs. When the residents were at home, one resident spent most of their time with staff when they were completing daily tasks and the other resident was relaxing in the garden room watching television.

The residents in both houses required additional communication support. It was evident that staff were able to freely communicate with the residents and were aware of their communication needs. Residents had visual aids and Picture Exchange Communication System (PECS) available to them. Where required, residents had been assessed by a speech and language therapist and recommendations were implemented. Residents also had access to an advanced autism practitioner who supported staff in developing plans to support the residents needs.

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

Capacity and capability

While governance and management systems were in place to oversee the quality of care delivered to residents, further actions were required to ensure the service

provided was safe, appropriate, consistent and effectively monitored, as referenced within this report.

This was a unannounced risk based inspection which was undertaken due to the length of time since the last inspection completed in January 2023. The purpose of the inspection was to assess the ongoing compliance with the regulations. The inspection was completed by one inspector over the course of one day. The registered provider for North Kildare is Gheel Autism Services CLG, who are involved in the running of several other designated centres in Ireland.

The service was led by a capable person in charge, supported by a staff team, who were knowledgeable about the support needs of the residents living in the centre. The person in charge, who was also a regional manager for the provider, worked full-time and had overall responsibility for two designated centres. On the day of inspection they were supported by a social care manager. While the person in charge worked full-time they informed the inspector that they were in the designated centre once every three weeks, with the social care manager in the centre once every second week. The inspector found that governance arrangements did not facilitate the person in charge to have adequate time and resources in order to fulfill their professional responsibilities. The inspector was informed that the provider was planning on changing the organisational structure in the upcoming registration renewal to make it more robust by having the person in charge over one centre only.

The registered provider had systems in place to monitor the quality and safety of care provided. Communication systems were in place between the registered provider and management within the centre. The person in charge had opportunities to meet with the registered provider at regional network meetings. Topics such as recruitment, safeguarding, incidents, complaints and facilities were discussed at these meetings. A restrictive practice committee had been established and met regularly with multi-disciplinary input from an advanced autism practitioner. Regular staff meetings were held and minutes maintained where aspects of residents' health and well-being, restrictive practice and incidents were discussed. Staff also prepared monthly keyworker reports for each resident which were discussed at the staff meetings.

The registered provider also had audit and monitoring systems in place to oversee the service. Actions identified for quality improvement, were assigned to a responsible person, with times for completion noted. Updates on these actions were discussed in management meetings. However, some audits did not identify issues that were observed on the day of inspection. While the provider had systems in place, these did not always identify or address areas for improvement within the centre.

On the day of inspection the registered provider was implementing a new online record management system. This impacted the availability of records on the day of inspection and led to delays in accessing some records and other records not being accessible by the inspector.

Regulation 15: Staffing

Staff worked across all three houses, which form the designated centre. On the day of the inspection, the designated centre was operating on a 1.5 full-time equivalent (FTE) social care worker staff vacancy. The inspector was informed that a staff vacancy was to be filled in January 2026 and further recruitment was taking place to fill the remaining vacancy. On the day of inspection, staff were limited in the activities they could do as they did not have a full complement of staff, due to an unexpected absence, which was required to meet the residents' needs.

Where possible, the person in charge was attempting to use regular agency staff to fill in for vacancies on the roster, which were due to both staff vacancies and planned leave. The inspector reviewed rosters in the centre from September to November 2025 and found that there was a high use of agency staff in the month of September, with them being used on 16 occasions to cover gaps on the roster. The use of agency staff had reduced in the month of November. The provider had completed a number of recruitment campaigns, however the inspector found the reliance of agency staff was effecting the continuity of support for residents in the centre.

The inspector observed staff engaging with residents in a respectful manner and it was clear that staff had knowledge of each residents assessed needs. Staff spoken to during the course of the inspection were aware of residents' changing needs and the supports that had been put in place in order to meet the needs of each resident in the centre. The inspector found that staff had the necessary competencies and training to support residents living in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the registered provider had implemented management systems to monitor the quality and safety of service provided to residents, this was not always effective. The provider had audits and regular meetings taking place which were identifying risks and areas for improvement. However, the inspector noted that time frames had not been implemented in relation to a number of outstanding works identified as required in the designated centre in relation to upkeep and repair of the premises across both houses which were visited by the inspector. For example, several premises issues like mould on some walls or staining from a previous leak in the kitchen/dining area were due to be completed in May and June 2025, however, these actions were still outstanding on the day of inspection. The meeting minutes template held sections for decisions, actions, person(s) responsible and action due

date which were not always completed, despite required actions being identified by the provider.

There was a risk register in place, which had recently been reviewed. However, some of the risk ratings in the register did not correlate with the actual risks within the centre and some of the risks had not been rated to inform of action action that was required.

While the person in charge worked full-time they informed the inspector that they were in the designated centre once every three weeks, with the social care manager in the centre once every second week. The inspector found that governance arrangements did not facilitate the person in charge to have adequate time and resources in order to fulfill their professional responsibilities.

Unannounced six monthly inspections were completed for each of the three houses which formed the designated centre separately. While they were taking place they were not completed at least once every six months. They were also ineffective at capturing and actioning key areas of improvement in the centre. They were conducted by the provider in the form of an observational narrative of the centre and it was not clear what regulations or standards were being reviewed and audited. The inspector found that the auditing system utilised by the provider for the six monthly unannounced inspections was not tailored to identify quality improvement in the centre.

The registered provider had a garden room in the back garden of one of the houses in the designated centre. This meant that the design and layout of the centre did not accurately reflect the facilities stated as provided within the statement of purpose. The inspector observed a resident use this as their preferred space throughout the inspection.

Good record-keeping is a fundamental part of good practice and an integral part of safe and effective care and support. On the day of inspection the registered provider was implementing a new online record management system, with the aim of improving record management. While records set out in the regulations were maintained, these were not easily retrievable. In addition, staff were also unable to access some of the records due to an unfamiliarity and lack of training provided for the new system in place, for example, some residents' personal plans.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose, which was available for review. However, it had not been reviewed at intervals of not less than one year, with it last being reviewed in September 2024. Generally, it contained the

information outlined in Schedule 1. However, some of the information contained in it was inaccurate. For example:

- The statement of purpose detailed that two of the three houses which make up the designated centre were respite services. The person in charge confirmed that only one house was a respite service.
- The registration conditions in the statement of purpose were not the current registration conditions for the designated centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector reviewed a record of incidents that occurred in the centre over the last year and found that the person in charge had notified the Chief Inspector of adverse events as required under the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The inspector requested a copy of the Schedule 5 policies at the start of the inspection. However, they were not readily or easily available to staff in the centre. The provider had begun to transition documentation to a new online system and the inspector was informed by the person in charge that this had impacted staff access to these files during this phase. During the inspection, the person in charge had requested access to the Schedule 5 policies. As policies became available, the inspector reviewed these, however, by the end of the inspection several policies were not available for review by the inspector so they could not be assured that the required policies were in place.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents' wellbeing and welfare were maintained by a good standard of care and support in the centre. The inspector observed kind and compassionate staff treating the residents with dignity and respect. Residents

appeared to be happy and content in their homes and with the service provided to them. However, improvements were required in relation to Regulation 17: premises.

The provider had ensured that the design of the premises provided all residents with equitable access to the services and facilities, regardless of their age, ability or disability. There was a calm and relaxing environment in the centre which added to a homely atmosphere. Residents had ample space within the centre to spend time alone which promoted their privacy and dignity. While the centre was generally laid out to meet the needs of the residents, improvements were required to ensure the premises was maintained to a good standard.

Regulation 10: Communication

Residents' could communicate freely and were assisted and supported to do so in line with their assessed needs. Residents' with additional communication needs were assessed by a speech and language therapist when required. The assessment was used to inform individualised communication plans for each resident. Staff spoken with were familiar with residents' communication needs and assisted residents to make informed decisions. Residents who required additional communication aids were supported to use these in a person-centred and respectful way. Staff interactions with each resident reflected the resident's individual communicative format.

Judgment: Compliant

Regulation 11: Visits

Visitors were welcome in the centre and encouraged to participate in residents' lives. Residents had access to suitable communal and private space, other than their bedroom, to meet with visitors in private. There were no visiting restrictions in place and visits facilitated did not negatively impact on any other resident in the centre.

Judgment: Compliant

Regulation 13: General welfare and development

Residents' are actively supported and encouraged to connect with family and friends and to feel included in their chosen communities. They had access to facilities for occupation and recreation both within the centre and within the community. Residents' had opportunities to participate in activities in accordance with their interests, capacities and developmental needs. They also had opportunities to take

part in a variety of activities that promoted their physical and mental health, enhance their well-being and encourage socialisation. For example, some residents' who were interested in health and fitness attended a local gym in their community for personal training sessions, and one attended a local weight loss club. One resident also volunteered in the local community.

Each resident was provided with appropriate care and support having regard to the resident's disability, assessed needs and their own wishes. Residents' were provided with opportunities to access independent advocacy if they wished and supported to have control over their daily lives. Residents' contributions and achievements were recognised and celebrated, which had a positive impact on their confidence and self-esteem. For example, where a resident wanted to live more independently they were supported to learn new skills and have opportunities to explore living alone in a supportive way

Judgment: Compliant

Regulation 17: Premises

While the premises were generally designed and laid out to meet the number and needs of residents in the centre, some areas required cleaning, maintenance and repair to ensure the premises was maintained to a good standard to meet the needs of the residents. For example:

- Parts of the designated centre had damaged walls from items being removed from the wall or cracks in the walls. Parts of the centre also had general wear and tear and walls required painting.
- Some repair work was also required to parts of the kitchen cupboards in one house and another house had damp stains on the ceiling in the dining room, which was due to be repaired in June 2025, however, still remained on the day of inspection.
- Some of the showers and ceilings in the bathrooms had mould stains which impacted effective clean in parts of the centre, which was due to be repaired in May 2025, however still remained on the day of inspection.

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	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant

Compliance Plan for North Kildare OSV-0007789

Inspection ID: MON-0043353

Date of inspection: 04/12/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The recruitment process was completed for the 1.0WTE and commenced their role as planned in January. The final advertised 0.5WTE role was also recruited successfully and commenced in post on the 20th January 2026.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Although issues identified in audit had been raised to the internal maintenance system and referred to the relating landlord and HSE Leaseholder, these were not completed in a timely manner. There was also one home which had the works actively underway but were incomplete still due to facilitating best times for the service provision and person supported. This matter was raised again with each relevant party for completion, highlighting the issue arising and seeking target dates. The risk register was reviewed to reduce risks which are no longer considered to be high and risks identified as high or very high were actioned to detail specific actions related. Biannual audits will be completed every six months going forward and will be based upon HIQA's Regulation 23 six monthly unannounced visit to Designated Centre Template' as a guide. A new updated floor plan will be submitted to ensure it reflects that the garden room is	

included within the footprint of the building.

The transfer of documents to the new online system has been complete for the team and a directory to guide the location of documents within, has been provided. The remaining schedule 5 policies have been transferred to a single page on Gheel's Intranet system to ensure access is easy to navigate.

As part of the Organizations' Governance plan over 2025, the new roles of Social Care Managers were rolled out which include the role of PIC within. The registration of the new PIC with HIQA for the area is also completed, which will support Governance and professional responsibilities.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
An revision to the SOP has been submitted alongside an update to conditions within and correction made to the related miswording of 'respite' which has now been updated to 'residential' for the home.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The remaining schedule 5 policies have been transferred to a single page on Gheel's Intranet system to ensure easy to find and navigate policies and schedule 5 policies for all staffs.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Although issues identified in audit had been raised to the internal maintenance system and in turn to the relating landlord/HSE Leaseholder, these were not completed in a timely manner. The issues related were raised again with each relevant party for completion highlighting the actions required arising and seeking a revised deadline for the works to be complete.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	13/03/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/06/2026

	are clean and suitably decorated.			
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	30/06/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	13/03/2026
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	Not Compliant	Orange	30/06/2026

	and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	01/01/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/06/2026
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	13/03/2026
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on	Substantially Compliant	Yellow	13/03/2026

	the matters set out in Schedule 5.			
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	13/03/2026