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:	Designated Centre 20
Name of provider:	St John of God Community Services CLG
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	23 June 2026
Centre ID:	OSV-0007904
Fieldwork ID:	MON-0041937

About the designated centre

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

Designated Centre 20 is a designated centre operated by St. John of God Community Services CLG. The designated centre consists of two houses. One house is located in a rural location near the County Kildare/Meath border and provides full-time residential services for up to three male adults. The house is a detached two-storey house with a large kitchen and dining area and two separate living room spaces. There is large outdoor garden and parking spaces. The second house is located in the centre of a busy town in County Kildare and can accommodate up to three residents either male or female. Residents have their own private bedrooms which have been decorated to residents' personal preferences and with due regard for residents' assessed needs. The centre is staffed by social care workers and health-care assistants and is managed by a person in charge who is also responsible for one other designated centre. They report to a person participating in management who supports them in their management role.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Tuesday 23 June 2026	10:35hrs to 17:40hrs	Anna Doyle	Lead
Wednesday 24 June 2026	11:10hrs to 17:15hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

Overall, while the inspector found that residents reported that they enjoyed a good quality of life in this centre, there were a number of improvements required to ensure a safe service for the residents. Significant improvements were required under fire safety, premises and governance and management. And some improvements were also required under records, staff, training, personal plans, risk management and residents' rights. As a result of the findings under Regulation 28: Fire precautions an urgent action plan was issued the day after the inspection to seek assurances on the fire safety arrangements in place.

This inspection was announced and was conducted to assure ongoing compliance with the regulations, and to inform a decision to renew the registration of the centre. The centre comprises of two properties; and is registered to support six residents. Three residents live in each property. The inspection occurred over two days and the inspector spent time in both properties associated with the designated centre.

Over the course of the inspection, the inspector met all six of the residents, and got to talk to five them about about what it was like to live in the centre. The inspector also spoke to three staff on duty, the residential coordinator who is also a person participating in the management of the centre, the new person in charge that was due to start in the centre in the coming weeks, and the director of nursing (over the phone). The inspector also conducted a walk around of both premises, observed some practices, and reviewed a sample of records specific to the residents' care, and the governance and management arrangements in the centre.

On arrival at the first property (House 1) on the first day of the inspection one of the residents welcomed the inspector to their home and requested to see the inspector's identification. Two residents were in the kitchen with staff having morning tea and refreshments and one of the residents was in the process of getting ready to go out for the day. Residents were making plans for the day ahead and invited the inspector to sit and chat for a while in the kitchen. The atmosphere in the house was relaxed and friendly. One of the residents showed the inspector around some of their home, including their bedroom. The resident told the inspector that they liked their bedroom, which was spacious and had a large couch where they could sit and watch television. The resident told the inspector that they wanted curtains on their bedroom windows. The inspector later found that the resident wanted the curtains to stop the light coming into their bedroom, in the early hours of the morning. This needed to be addressed going forward.

The inspector also observed from walking around this property that a considerable number of upgrades and modifications were required to this property, some of which had been recommended by an occupational therapist for one resident in 2023. As a result of these findings, Regulation 17: Premises was found not

compliant, the details of which are discussed under this regulation later in this report. The inspector also observed that due to some negative interactions between residents, one resident was now having their meals in the sitting room. While the staff informed the inspector that this was the residents preferred option, and that the resident was not prevented from having their meals in the dining room. The inspector found that this had not been reviewed fully to ensure that this arrangement was not impacting on the residents' rights in the centre. This is discussed under Regulation 9: Residents rights of this report.

On arrival at the second property (House 2) on the second day of the inspection, all of the residents were attending a day service. This property was modern, spacious and decorated to a high standard. Each resident had their own bedroom, there was a large kitchen and open plan living room area, that included a sitting area, a dining area, and a leisure area that had a large hockey table and some other equipment and games that residents enjoyed. The inspector observed the staff and two of the residents enjoying some of these games when the residents returned from the day service they attended. Two of the residents showed the inspector their bedrooms which were decorated in line with their preferences and wishes. As an example; the inspector observed that one resident had pictures on a radiator, waiting to be hung on the wall, the staff had informed the inspector that the resident liked to take their time when deciding when to hang them up. When the inspector spoke to the resident about this, they confirmed this and said they really had not decided yet when to hang them up as they liked things in a particular way. This was an example of how the resident's choice was respected.

As part of the inspection process, questionnaires are sent out by the Health Information and Quality Authority (HIQA) to collect the views of residents and or their family representatives prior to the inspection. The inspector was provided with four completed questionnaires that residents had completed with the support of staff members. Overall the feedback was positive, with residents recording that they were happy living there and liked their home. However, one resident stated that as mentioned earlier that they would like new curtains in their bedroom.

Residents were supported to keep in touch with their family and friends. One of the residents informed the inspector that they liked to choose when they went home to visit relatives. Another resident preferred their family to visit them and the staff informed the inspector that an open door policy was promoted in the centre, meaning residents' visitors were welcome anytime.

The staff went through some of the needs of the residents and also the systems in place to assure a safe service to the residents. For example, the fire evacuation procedure to be followed in event of a fire, the different types of abuse and who to report them to, and some of the specific supports that residents needed in relation to their healthcare needs. The inspector found that staff were knowledgeable for the most part about these systems and support. However, the fire evacuation procedure in House 2 was not clear. In addition to this in House 1, there was no emergency lighting in one area of the property, even though it had been recommended following an audit of the centre in 2022. As a result of this and other observations

over the course of the inspection, Regulation 28: Fire precautions was found not compliant.

Mealtimes were observed to be a positive experience, and residents and staff were observed sitting down having dinner together on the second day of the inspection. The meal was relaxed and everyone was talking about their day. All of the residents said that they liked the meals that were provided. On the first day of the inspection all of the residents had also went out for lunch.

Residents were supported to maintain their independence and develop new life skills. One of the residents, for example, walked to and from their day service and was learning to make some meals with staff. The resident informed the inspector that they were really enjoyed this.

The inspector observed examples, of residents interests and hobbies being promoted in the centre. One of the residents was really interested in drama and spoke about a drama group they attended and some shows that they had been part of. Another resident was really interested in specific models of cars. The resident spoke for a while to the inspector about this, and the inspector also observed the resident talking to staff about car models over the course of the inspection. Some of the residents had been to an annual black-tie event and had photographs of this event in their sitting room. Another resident loved music and had their own collection of compact discs by music artists that they liked. Residents had also been to rugby matches, the theatre, or went on holidays.

The inspector observed, a number of forums where residents could express their views or be informed about the management of the centre. Residents' meetings were held each week to inform residents about things that were happening in the centre, to collect their views on aspects of the service, and to provide some education about the residents' rights, keeping safe, to plan meals, and to make some plans for the coming week about things they wanted to do. The inspector observed in one meeting that residents had requested more one to one time with staff rather that group activities all the time, and this was facilitated.

Overall residents reported that they liked living in the centre and were enjoying a good quality of life. Notwithstanding improvements were required in a number of regulations to assure that the provider was meeting the requirements of the regulations.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements affected the quality of care and support being provided to residents.

Capacity and capability

Overall, given the findings of this inspection, the inspector was not assured that the governance and management systems in place in the centre were effective. The governance arrangements were also not assuring that all actions were completed from audits conducted in the centre, or that in instances where actions were not completed in a timely manner, that the registered provider had assessed the impact this would have on the quality and safety of care provided to the residents in this centre. Improvements were also required under staffing, training and records stored in the centre.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted an application to the Chief Inspector to renew the registration of the designated centre which included all of the documents that are required to be submitted with this application.

Judgment: Compliant

Regulation 15: Staffing

Overall, the staffing requirements in place ensured the assessed needs of residents were met. Some minor improvements were required in relation to the maintenance of Schedule 2 documents as required under the regulations.

The skill mix included social care workers and health care assistants. There were adequate numbers of staff on duty to support the residents needs. In House 1, three staff were on duty each day, and at night there was a waking night staff and a sleepover staff. In House 2, there were two staff on duty for most of the day and a waking night staff.

A planned and actual roster was maintained, showing the staff that worked each day in the centre. A review of a sample of rosters worked in November 2025 and June 2026 showed that there was a consistent staff team employed and that the staffing arrangements outlined above were in place. This review also showed that where relief or agency staff were employed, they were the same consistent staff members. The registered provider was also responding to the needs of the residents in the centre. For example in House 1, additional staff had been rostered each day due to peer to peer safeguarding concerns in the centre.

On call arrangements by senior managers was also provided should staff need guidance or assistance. The residential coordinator was a registered nurse, and was able to offer guidance and support to staff about some of the residents' healthcare needs.

The inspector reviewed the staff files of three staff members. They contained most of the the requirements of Schedule 2. For example; all staff had been vetted with An Garda Síochána (police). However, there were some gaps in the employment history of two staff at the time of the inspection.

The registered provider submitted written confirmation after the inspection confirming that there was an agreement in place which assured, for example, that agency staff had been vetted with An Garda Síochána (police) and that they had specific training completed prior to working in the centre. The inspector also followed up on a special notice that had been issued by the Chief Inspector of Social Service to all registered providers regarding the use of agency staff. This notice included the importance of checking agency staff members photo identifications prior to the staff working in the centre. The director of nursing confirmed that this had been reviewed by the registered provider and that checking the photo identifications for agency staff was now required as part of the agency staff members induction to the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were required to complete training in order to meet the needs of the residents and to assure that a safe quality service was provided to them. Some staff were also due to complete refresher training and there were plans in place for staff to attend this training in the coming weeks and months. However, improvements were required as some staff had completed training in specific areas and some had not.

The inspector reviewed the training requirements in place and saw that staff were required to have training completed in the following areas:

- AMRIC - Basics of Infection & Prevention Control
- AMRIC - Hand Hygiene
- AMRIC - Personal Protective Equipment
- AMRIC - Respiratory Hygiene and Cough Etiquette
- AMRIC - Standard and Transmission-Based Precautions
- Children First
- Safeguarding of Vulnerable Persons
- Fire Safety
- Food Safety
- Manual Handling
- Crisis Prevention Intervention
- Human Rights
- Safe Administration of Medication
- Staff Safety
- First Aid
- Communication

- Dysphagia Training
- Food Safety Training

However, some staff had not completed communication training, dysphagia training, food safety training and first aid training at the time of the inspection. The residential coordinator informed the inspector that they had recently identified that first aid training was required in House 1 due to the location of the premises, and the time it would take emergency services to respond to the premises. This needed to be reviewed to assure that the training required to support the residents was completed by all staff.

The staff met felt supported in their role. There was a schedule in place for staff to receive supervision. A sample of records viewed indicated that staff had not raised any concerns about the quality of care provided.

Where new staff were employed the registered provider also had an induction pack that staff had to complete to ensure they were familiar with policies and procedures and practices in the centre.

Judgment: Substantially compliant

Regulation 21: Records

The inspector reviewed the records in place as required under the regulations and associated schedules. On review of residents' person plans the inspector noted there were gaps in the records kept in relation to referrals and follow up appointments. The inspector had to seek assurances and follow up in relation to the following:

- A referral to speech and language therapy for one resident.
- A referral for a resident for a dexascan to be completed.

Judgment: Substantially compliant

Regulation 22: Insurance

As part of the application to renew the registration of the centre, the registered provider had submitted a valid insurance certificate which included cover for the building and all contents and residents' property.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector found that improvements were required in a number of regulations at this inspection, this did not provide assurance that the governance and management arrangements were effective at the time of this inspection. The oversight and management of fire safety required considerable review and improvements. There was a lack of timely response from the provider in relation to recommendations from audits and recommendations from health and social care professionals that was directly impacting on the quality and safety of care.

The registered provider had systems and personnel employed to audit the services provided. However, some actions from these audits were not completed or if actions had been completed there were limited records in place to evidence this. Below are examples of identified actions that remained outstanding on the day of inspection.

- An audit of fire conducted in 2022 had made a number of recommendations regarding the fire safety systems in the centre. The registered provider had noted that resource issues were a barrier to completing these. However, one of the recommendations made was easily fixed and did not require additional resources to address, and this had not been completed. Some of the recommendations were required to be in place within six months of the audit being completed and these were not done. The inspector found that there had been no review of this audit to ensure how the registered provider was meeting the requirements of the regulations in the absence of these recommendations being addressed.
- A review conducted by an occupational therapist in 2023 made specific recommendations regarding modifications to the premises to meet one residents' needs, which had not all been completed at the time of this inspection. There also was no review of these recommendations to ensure that the residents' environment was safe, given that these recommendations were not all implemented.
- It was also not clear from the registered provider's quality enhancement for the centre if some of the actions from other audits had been completed. For example, improvements were required in aspects of the maintenance of the premises. Some of these actions were marked as in progress, such as repairs of kitchen cabinets and the replacement of curtains. However, there were no clear records showing if these actions were completed. The inspector reviewed an audit completed in June 2024, which identified that curtains needed to be replaced. This action was open on the day of inspection. Following conversations with staff it was found that this action had been completed but failed to be updated on the audit. Therefore there was no clear tracking system in place in terms of actions being completed or in progress.

Overall, these issues, and all the findings in relation to audits and reviews of the service did not provide assurances to the inspector about the oversight arrangements in this centre.

As well as this, at the time of the inspection, the person in charge had resigned and a new person in charge had been appointed who was due to commence employment the week after the inspection. In the interim, the residential coordinator was assigned to oversee the regulatory responsibilities of the person in charge. As person in charge their managerial remit included the management of this centre and another designated centre

The inspector asked about the arrangements in place to support the person in charge as they were responsible for two designated centres which comprised of three locations. The inspector was informed that there were no arrangements to support the person in charge with their role. The inspector was not assured by this arrangement, given the findings of the current inspection. Although some assurances were given to the inspector around this on the day of inspection further actions were required to ensure that the centre was adequately resourced.

The registered provider, also needed to review the training provided to staff to assure that it met the needs of the residents living in the centre. For example; as stated under Regulation 16: Training, some staff had completed training and others had not.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed by the inspector and found to meet the requirements of the regulations. It detailed the aims and objectives of the service and the facilities to be provided to the residents.

This document had also been reviewed recently which is a requirement under the regulations to update the statement of purpose on an annual basis (or sooner). Some minor improvements were required to ensure that the arrangements for the person in charge who was responsible for one other centre, was included in this document, however this was completed on the first day of the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of the adverse incidents that occurred in the centre since January 2026, informed the inspector that the person in charge and registered provider had notified the Chief Inspector of Social Services of any relevant adverse incidents within the specified time frames required under the regulations.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The registered provider was aware of their responsibilities to notify the Chief Inspector, of the procedures and arrangements for periods when the person in charge was absent from the designated centre.

Judgment: Compliant

Quality and safety

Overall, the residents in this centre reported that they liked living here and enjoyed a good quality of life and, got to do things they liked. However, there were a number of improvements required to one property to assure that it met the requirements of the regulations and the needs of one of the residents living in this property. Significant improvements were also required in fire safety which resulted in an urgent action plan being issued the day after the inspection to the registered provider seeking assurances around fire safety compliance. The inspector also found that improvements were required in risk management, personal plans and residents' rights.

Regulation 13: General welfare and development

As discussed under the section 'What the residents told us and what the inspector observed' of this report', residents were provided with opportunities to take part in a variety of activities that matched their interests and hobbies. One of the residents was really interested in drama and spoke about a drama group they attended and some shows that they had been part of. Another resident was really interested in specific models of cars. The resident spoke for a while to the inspector about this, and the inspector also observed the resident talking to staff about car models over the course of the inspection. Some of the residents had been to an annual black-tie event and had photographs of this event in their sitting room. Another resident loved music and had their own collection of compact discs by music artists that they liked. Residents had also been to rugby matches, the theatre, or had went on holidays.

Residents were supported to maintain their independence and develop new life skills. One of the residents, for example, walked to and from their day service and

was learning to make some meals with staff. The resident informed the inspector that they were really enjoyed this.

Residents were supported to keep in touch with their family and friends. One of the residents informed the inspector that they liked to choose when they went home to visit relatives. Another resident preferred their family to visit them and the staff informed the inspector that an open door policy was promoted in the centre, meaning residents' visitors were welcome anytime.

Judgment: Compliant

Regulation 17: Premises

The designated centre comprised of two properties. While the inspector observed that House 2, visited on the second day of the inspection was finished to a high standard, spacious and clean. House 1 which was visited on the first day of the inspection was observed to require significant upgrades to the inside of the property and external areas of the property needed to be addressed in terms of accessibility for residents. For example, an occupational therapist had conducted an environmental assessment in House 1 for one resident in 2023. This assessment had made several recommendations most of which had not been completed at the time of this inspection. Those that were not completed included:

- Installing high contrast yellow lines on the edges of the floor
- The edge of steps leading out of the property should also have high contrast yellow lines
- Removing saddle boards in the premises to prevent a trip hazard
- Resealing loose tarmac to the front of the property around the steps
- Widening the pathway surrounding the property to improve accessibility for the resident
- Installing sliding doors to the back of the property to improve accessibility for the resident

It was also observed in the registered providers own audits and reviews of the premises that a number of other improvements were required:

These included

- Painting the interior of the home, including residents' bedrooms
- Addressing the flooring in some areas of the home, including the hallway as it was uneven.
- The flooring in the staff sleepover room needed to be replaced.

The inspector also observed that on the day of the inspection, that some other upgrades were required. Some of the radiators were rusted, and the inspector noted a malodour coming from one en-suite bathroom. The residential coordinator informed the inspector that this was an ongoing issue, and that several actions had

been take to try and address this. However, it needed to be addressed going forward for the resident who used this en-suite bathroom.

The inspector also observed in one residents' questionnaire that they would like black out curtains for their bedroom. The resident also spoke about this when they were showing the inspector around their bedroom. When the inspector asked about this, they were informed that this would be addressed when the bedroom was painted. This needed to be addressed in a timely manner as the reason the resident wanted the curtains was to stop the light coming into their room when they were asleep.

The registered provider had systems in place to ensure that equipment in the centre was being maintained. For example, Portable Appliance Testing (PAT) was scheduled to take place this year. However, the records of the previous PAT conducted, could only be verified by the inspector checking the label on one piece of equipment. The inspector also found that the service record of the boiler was attached to the actual boiler, however there was no service record to assure that there had been no issues noted at the last service which was August 2025. This needed to be reviewed to assure that all service records regarding the equipment in the centre were available to verify that the equipment in the centre was in good working order.

Judgment: Not compliant

Regulation 20: Information for residents

The registered provider had prepared in writing a guide in respect of the designated centre. This guide was available to the residents and included a summary of the services to be provided, how residents should be included in the running of the centre and where residents could access inspection reports carried out in this centre by the Health Information and Quality Authority (HIQA).

Judgment: Compliant

Regulation 26: Risk management procedures

The systems in place to manage risk in the centre required some review. The registered provider had a risk register in place identifying controls in place to manage and mitigate risks to the residents. The inspector was informed that there were no risk assessments in the centre rated as an orange or red risk which would require reporting this to senior managers.

The inspector reviewed a sample of risk assessments included in this register and found that some of the controls listed by the provider were not in place. As an example, one risk assessment stated that all staff should have dysphagia training completed, however not all staff had this training at the time of this inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not have effective governance arrangements in place for fire safety. Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response provided assurance that the risk was adequately addressed.

As a result of the improvements required under this regulation as stated an urgent action plan was issued to the provider, the day after the inspection. This urgent action plan required the registered provider to submit written assurances by the 02 July 2026 to the Chief Inspector to include the actions the provider intended to take to be in compliance with the regulations. In the urgent action plan the registered provider had to outline how they would address the identified issues in relation to emergency lighting and ensuring residents had a safe place to assemble at if a fire broke out in the centre.

On the first day of the inspection, the inspector observed that there were no emergency luminary signs on the final exit doors which were located in the kitchen and sitting room. In addition there was no emergency lighting installed in these areas which would mean they would be in darkness in the event of a relevant emergency. The inspector viewed a report of an audit that had been commissioned by the registered provider in 2022 by a competent fire company to assess compliance with fire safety regulations. This report had highlighted a number of improvements to the fire safety systems in this premises. These improvements included the installation of emergency lighting in the kitchen and sitting room, with a recommended time frame of six months for completion. This had not been completed at the time of this inspection. The audit had also recommended that a zone map should be placed beside the fire alarm panel in the centre. This had not been completed and when the inspector asked about the zones displayed on the panel, the staff were not sure about where these zones referred to in the premises.

The inspector was informed that some of the works recommended from the fire audit conducted, required additional funding to be approved to complete all of the recommendations. This funding had only recently been approved by the funding body. However, there was no documents to verify that a review had been conducted to inform, how the registered provider was assured that between the time of the audit in 2022 to the time of the inspection, that they were assured that they were

meeting the requirements of fire safety regulations, in the absence of these recommendations being completed.

On review of fire drills the inspector found in House 2, that a fire drill had not been completed to reflect a real-life scenario, when there was a minimum of one staff on duty to ensure that residents were brought to a safe location. The fire drill procedure through the front exit door of the property did not have a thumb turnkey lock to assure that it could be readily opened at all times. The inspector also conducted a walk through of the fire procedure with staff through this escape route. The fire evacuation route required residents to evacuate through the front door, and enter a gate to arrive at the fire assembly point. However, there was no mechanism to open this gate meaning that residents could not enter the area to get to the fire assembly point. The inspector was also not assured that the location of this fire assembly point was appropriate given the potential location of the fire in a real life scenario. This needed to be reviewed to assure that residents were brought to a safe location in the event of a fire.

The inspector also observed that records of fire drills, did not record the exits used during the fire drill and weekly fire checks conducted by staff did not include checking the fire blanket in the kitchen.

Overall, the inspector was not assured that appropriate fire safety measures were in place on the day of inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

At the time of the inspection, the registered provider was transferring residents records from paper records onto an online system. Residents had assessments of need conducted and a sample viewed showed that they had been recently updated. There were plans in place detailing the supports that residents needed with their assessed needs. One resident who spoke to the inspector were very familiar with their needs and the supports that they needed. They spoke about how staff for example, supported them with some of their healthcare needs, and medical appointments they attended.

The staff spoken with were familiar with a sample of needs discussed with them. For example, in House 2 they described when a resident may require emergency medical advice and support.

However, as discussed under Regulations 23: Governance and management, recommendations from an occupational therapist had not been implemented in a timely manner.

In addition, the inspector also observed that some residents' personal support plans needed to be updated to reflect the residents' support needs. For example, it was

noted in one resident's plan that the resident required full support to manage their personal monies. However, when the inspector spoke to a staff member, the resident was able to manage aspects of their own money. This needed to be reviewed also to assure that the plan reflected the residents independence in this area.

Judgment: Substantially compliant

Regulation 8: Protection

All staff had completed training in safeguarding vulnerable adults. Where incidents had been reported to the Chief Inspector, the provider had reported it to the relevant authorities and taken steps to safeguard residents.

Since the last inspection of the centre, the Chief Inspector had been notified of a number of allegations of abuse that had occurred in the centre. The majority of these allegations related to negative peer to peer interactions. The staff team had implemented strategies to reduce the likelihood of these interactions occurring. One of those strategies included that a resident ate in a separate room and spent most of their leisure time in this room when they were not out in the community. While the staff informed the inspector that the resident actually preferred this arrangement due to their assessed needs, the inspector was not assured that this arrangement was not impacting on this residents and other residents' rights to have access to all areas of their home. This is actioned under Regulation 9: Residents rights of this report.

As stated earlier in the report, all of the residents had recorded on their questionnaires that they felt safe. The residents who spoke to the inspector said that they liked the people they shared their home with and liked the staff team. The residents informed the inspector that they would talk to staff if they did not feel safe or were not happy.

At the time of this inspection, there were no complaints on the quality and safety of care provided. The staff who met with the inspector were aware of the different types of abuse and the reporting procedures in place should an incident occur. The residential coordinator and the staff informed the inspector that they had no concerns about the quality and safety of care provided.

Judgment: Compliant

Regulation 9: Residents' rights

As referenced under Regulation 8: Protection, safeguarding measures implemented to reduce the likelihood of negative interactions between peers in one of the properties, needed to be reviewed to assure that it did not compromise residents' rights to have access to all areas of their home.

Residents were supported to maintain their independent living skills, such as walking to work.

Residents were included in decisions about their home and were kept up to date about changes in their home. For example; all of the residents had been informed about the inspection of this centre when it was announced. They were informed about when equipment was broken, and their choices were respected.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Designated Centre 20 OSV-0007904

Inspection ID: MON-0041937

Date of inspection: 24/06/2026

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The two staff files referenced were reviewed and updated to address the identified gaps in employment history. 30/06/2026	
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 conduct a review of all staff training requirements to ensure that training is aligned with resident's assessed needs. A training plan will be implemented to ensure that all staff complete outstanding communication, dysphagia, food safety, and first aid training within specified timeframes. Particular emphasis will be placed on ensuring adequate first aid training in House 1, taking into consideration the location of the premises and the potential response times of emergency services. The training matrix will be updated and monitored regularly to ensure ongoing compliance. 30/09/2026	

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Person in Charge (PIC) will review all resident's personal plans to ensure that referrals, recommendations, and follow-up appointments are clearly recorded, tracked, and acted upon in a timely manner. The PIC will ensure that all documentation required under Schedule 3 is maintained within each resident's personal plan and is current, complete, and readily accessible. Progress on identified actions will be monitored on an ongoing basis, with appropriate follow-up and escalation where required. 31/08/2026	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The status of all outstanding audit actions on QEP 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 Registered Provider will review the management and governance arrangements within the designated centre to ensure the Person in Charge (PIC) is adequately supported in carrying out their regulatory responsibilities across all designated centres and locations under their remit. 15/10/2026 • Training compliance will be reviewed monthly by the PIC, with outstanding training discussed through supervision, staff meetings, and governance forums to ensure full compliance is maintained. 10/10/2026	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The Registered Provider will complete a comprehensive review of House 1 to identify and prioritise all environmental improvements required to ensure the premises are safe, accessible, and meet the assessed needs of residents. The recommendations contained within the Occupational Therapist's environmental assessment will be reviewed. An action plan will be developed, with responsibility assigned for the completion of all outstanding works. The provider will ensure that internal repairs, upgrades, and external	

accessibility issues are addressed.30/11/2026
• The Person in charge will ensure that curtains are purchased and installed in the resident's bedroom to complement the blackout blinds already in place, ensuring that external light is minimised and the resident's comfort, sleep quality, privacy, and individual preferences are supported. 30/08/2026
• The person in charge shall ensure that all PAT testing of Portable Appliances is completed and will hold a record of same. 10.012.2026
• Service record for the heating system will be maintained in the house as part of maintenance and service records 22/7/26

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge will review the risk register to ensure that all identified control measures are in place. The remaining staff are scheduled to complete Dysphagia training.
30/08/2026

Regulation 28: Fire precautions	Not Compliant

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

• Additional Emergency Lighting has been installed for identified exit routes. This action will strengthen the centre's fire safety management systems and ensure compliance with fire safety requirements.
• The Person in Charge will ensure that a zone map will be placed beside the fire panel in the centre and that all staff are aware of same. 30/08/2026
• 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
• The Local Emergency Evacuation Plan for the area identified during the inspection has been reviewed. The assembly point has been relocated. Residents and staff are familiar with the revised arrangements, and all appropriate fire safety documentation has been updated. The manual gate override procedure is now clearly documented, with photographic guidance available to support staff in safely and effectively opening the

gates manually in the event of an emergency or loss of power. These measures enhance the effectiveness of the centre's fire safety management systems and support the safe evacuation of residents. 30/06/2026
• The person in charge will ensure that the exits used during fire drills are recorded.30/08/2026
• The health and safety officer will review the checklist with a view to including fire blankets. 30/08/2026

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• A monthly audit of personal support plans will be implemented by the person in charge to ensure reviews are completed in line with the centre's policy and any changes in residents' needs are reflected promptly. 30/09/2026

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A review of the safeguarding measures implemented within the centre will be completed to ensure they are proportionate, person-centred, and do not unnecessarily restrict resident’s access to any areas of their home. The review will consider resident's rights, individual risk assessments, safeguarding plans, and compatibility support arrangements. Where restrictions are identified, less restrictive alternatives will be explored and implemented where appropriate. 15/09/2026

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 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	30/06/2026
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	30/09/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and	Not Compliant	Orange	30/11/2026

	objectives of the service and the number and needs of residents.			
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	30/11/2026
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	10/12/2026
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/08/2026

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	15/10/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/08/2026
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	02/07/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/09/2026
Regulation 05(6)(d)	The person in charge shall	Substantially Compliant	Yellow	30/09/2026

	ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	15/09/2026