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:	Oak Hill
Name of provider:	St John of God Community Services CLG
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	13 January 2026
Centre ID:	OSV-0007954
Fieldwork ID:	MON-0049253

About the designated centre

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

This is a service providing care and support to four adults with disabilities. The centre comprises of a large four bedroom dormer bungalow, a sitting room, a large kitchen cum dining room, a large second sitting room, a utility room, communal bathroom facilities and a staff office on the first floor. Each resident has their own fully furnished spacious bedrooms complete with walk in wardrobes (with one bedroom one being ensuite). Private garden areas are provided to the front and rear of the property with the provision of adequate private parking to the front of the property. The house is located in a peaceful rural setting but within easy access to a number of villages and towns. Private transport is also available to the residents for social outings and trips further afield. The service is staffed on a 24/7 basis with a person in charge, and a team of staff nurses and team of healthcare assistants.

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
Tuesday 13 January 2026	10:30hrs to 17:30hrs	Miranda Tully	Lead
Tuesday 13 January 2026	10:30hrs to 17:30hrs	Michael Muldowney	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the regulatory monitoring of the centre and in response to unsolicited information about the quality and safety of the service provided to residents. This inspection was completed by two inspectors over the course of one day. Inspectors used observations, conversations with staff, and a review of documentation to form judgments on compliance.

Overall, they found that the centre was operating at a good level of compliance with the regulations. There were effective governance and management arrangements, and residents were receiving appropriate care. However, improvements were required to the staffing arrangements to ensure that they were in line with residents' assessed needs. In addition, Inspectors found that one resident's specific health care plan required further review and cohesion to ensure that it outlined all associated interventions for staff to be aware of.

The person in charge told inspectors about the residents' complex healthcare and support needs. They were satisfied that they were safe and that their needs were met in the centre; for example, the premises were appropriate and residents could access multidisciplinary team services. The person in charge was also complimentary of the staff team and said that they knew the residents well. However, the staffing arrangements required enhancement to ensure that staffing levels were appropriate to the residents' assessed needs. This matter is discussed further later in this report.

Overall, it was clear that the person in charge had a rich understanding of the residents' needs and individual personalities. They also had effective oversight of the quality and safety of the service, and ensured that associated risks were managed.

The inspectors spoke with senior management of the centre during the inspection. They told inspectors that they had no concerns for the residents' safety, and were satisfied with the governance and management of the centre. They said that residents had a good quality of life, and that their families were complimentary of the care and support they received. They were satisfied that risks and incidents in the centre were appropriately managed. They told inspectors that the provider was continuing to escalate the need for additional staffing resources with their funder.

Inspectors spoke with a staff nurse during the inspection. They were found to have an excellent understanding of the residents' care and support needs, and the associated interventions to be in place. The nurse also described the procedure for responding to and reporting concerns, including safeguarding concerns and complaints, which were in line with the provider's policies and procedures. They had no concerns, but said that residents could have an enhanced quality of service if additional staffing resources were available. Inspectors also observed the nurse engaging with residents in a kind and warm manner.

Inspectors met all four residents. They did not communicate their views. On the day of the inspection, residents spent time watching television, and going to a nearby farm and coffee shop. Inspectors reviewed a sample of their December 2025 daily record notes which outlined various activities that the residents had engaged in, including shopping, attending social clubs, receiving therapeutic treatments, going for walks and to cafés, watching television, and listening to music. Inspectors also read a sample of the residents' social goal records, which recorded achieved goals, such as going on hotel breaks, and to concerts and events.

The premises comprised a large two-storey house on the outskirts of a small rural village. The house was set on a large site in a peaceful country side environment. Inspectors observed that the house was warm, clean, bright, spacious, well maintained, comfortable, and nicely decorated. Residents bedrooms were tastefully decorated, had personal items on display and provided adequate storage for their personal belongings.

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

Capacity and capability

Residents were found to be receiving a good standard of care at the time of inspection; however, the staffing arrangements continued to require review. At times, there were not enough staff available to safely meet residents' assessed needs.The staffing arrangements on the day of inspection included a qualified nurse on duty 24 hours, they were supported by two health care assistants during the day and one health care assistant at night. This has been identified in previous inspections of the service; however, the provider had not adequately addressed the staffing issue at the time of the most recent inspection.

Clear lines of authority and accountability were in place within the service. The centre was led by a suitably qualified and experienced person in charge, who was supported by a senior manager involved in the management of the centre. The inspectors met with members of the senior management team as part of their inspection.They told inspectors that they had no concerns for the residents’ safety, and were satisfied with the governance and management of the centre. The person in charge and person participating in management held monthly meetings which reviewed the running of the centre.

Staff had access to and have completed training that is up to date and appropriate to the service provided, their role and the needs of residents.

The person in charge had ensured that incidents occurring in the centre were notified to the Office of the Chief Inspector of Social Services in accordance with the requirements of the regulations.

The provider has established and implemented effective complaint handling processes to attain the most appropriate outcome for residents. All staff were provided with the appropriate skills and resources to deal with a complaint and had a full understanding of the complaints policy.

Regulation 15: Staffing

Staffing levels were identified as requiring review during the last inspection in August 2025, and inspectors found during this inspection, that the registered provider had still not ensured that appropriate staff numbers were maintained in line with residents' assessed needs.

Since the previous inspection, the provider had submitted a business case to their funder for additional staffing resources. The business case outlined that additional staffing resources were required for residents' manual handling, intimate care, supervision, attendance at appointments, and social goals. The inspectors were informed during the inspection that the case had not been approved. Staff told the inspectors that the associated risks could adversely impact on residents, but they endeavoured to manage them as best they could.

There were three staff working each day in this centre, one staff nurse and two health care assistants. Staff carefully planned the day to try and ensure that residents needs were met for example; outings were planned at particular times when other residents' needs were predicted to be less.

On the day of this inspection two residents went on a social outing with support from two staff members (one of these residents was 1:1 staff support) and two residents remained in the house. The residents who remained in the house required 2:1 support for personal care. This meant that during the the timeframe the other residents were on a social outing, it was not possible to support those residents with personal care if they required it.

However, despite staff planning this could not be guaranteed and could result in limited opportunities for the residents on outings and could impact residents who required 2:1 support with personal care as there were not sufficient staff in the centre in these circumstances.

Inspectors also found from reviewing associated documentation and speaking with staff, that the risk of insufficient staffing on residents' quality and safety of service required further assessment and detail on the potential adverse impacts to residents. The management team were aware of this, and planned to review the associated risk assessment and enhance the recording systems.

Inspectors found that the maintenance of staff rotas required improvement. Inspectors reviewed the rotas between October and December 2025. They found that staff names and the hours they worked in the centre were not recorded on all occasions. Additionally, shift codes were not explained, and therefore the hours worked by staff were difficult to decipher. The rotas also showed that planned staffing levels were not always maintained. For example, in December 2025, there was one day when only two staff were on duty. This posed a further risk the quality and safety of residents' care.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training as part of their professional development and to support the delivery of effective care and support to residents.

Inspectors reviewed the staff training logs with the person in charge. The records showed that staff were up to date with their required training, and had completed training programmes, included on the safeguarding of residents from abuse, fire safety, manual handling, basic life support, behaviour support, infection prevention and control, administration of medication, epilepsy management, and supporting residents with modified diets.

Judgment: Compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure in place which was led by a person in charge. The person in charge had monthly meetings with the person participating in the management of the centre. Inspectors reviewed a sample of their meeting records from 2025 and 2026. They noted a wide range of topics, including incidents, safeguarding concerns, complaints, restrictive practices, risks, notifications, staffing matters, the premises, and residents' plans. The inspectors spoke with senior management of the centre during the inspection. They told inspectors that they had no concerns for the residents' safety, and were satisfied with the governance and management of the centre.

As noted previously, the registered provider had not ensured that appropriate staff numbers were maintained in line with residents' assessed needs. While the provider was in the process of developing a risk management plan and protocol to support

staff when lone working in the centre, further action was required to ensure adequate resources.

The designated centre was being audited as required by the regulations and an annual review of the service had been completed for 2024 along with six-monthly unannounced visits to the centre carried out in January and July 2025. These audits were to ensure the service was meeting the requirements of the regulations and was safe and appropriate in meeting the needs of the residents. An audit schedule for 2026 had been developed to included audits such as finance, hygiene, medication, fire and individual personal plans on a six monthly basis.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had ensured that incidents occurring in the centre were notified to the Chief Inspector of Social Services in accordance with the requirements of this regulation.

Inspectors reviewed a sample of the incidents occurring in the centre, which included the use of restrictive practices, minor injuries to residents, and allegations of abuse. They found that the incidents had been appropriately notified.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had prepared an effective complaints procedure. The procedure was underpinned by a written policy, which included information on advocacy services and how complaints were to be managed. The procedure had also been prepared in an easy-to-read format to make it more accessible to residents and their representatives.

Staff spoken with during the inspector were aware of how to response and record any complaints made by residents or their representatives. The person in charge maintained a complaints register. The last complaints recorded were from 2023. They had been raised by staff on residents' behalf, and had been escalated to the necessary parties. The complaints were opened, but the person in charge expected that they could be closed soon.

Judgment: Compliant

Quality and safety

Residents assessed needs were for the most part clearly documented within their individual care plans, and appropriate systems were in place to support and promote their well-being. Inspectors found that one resident's specific health care plan required further review and cohesion to ensure that it outlined all associated interventions for staff to be aware of.

Effective risk management systems were implemented, with each resident having individual risk assessments completed.

Safeguarding measures were also in place to protect residents, and any adverse incidents occurring within the centre were appropriately responded to and investigated.

At the time of the inspection, the person in charge, person participating in management and regional director of services confirmed there were no outstanding complaints relating to the service and that no aspect of care quality or safety was subject to investigation. In addition, there were no active safeguarding concerns identified at that time.

Regulation 26: Risk management procedures

There were effective arrangements for the identification, assessment and management of risks in the centre. These arrangements were underpinned by the provider's written risk management policy. Inspectors also found that incidents occurring in the centre were appropriately recorded, reported and reviewed to identify actions to reduce the likelihood of them reoccurring.

Inspectors reviewed the centre's risk register as well as a sample of the residents' individual risk assessments. The risk assessments were wide in scope and included matters, such as accidental injury, behaviours of concern, infection prevention and control, and environmental risks. The risk assessments were up to date, and outlined the associated control measures. Inspectors reviewed a sample of the control measures, and found that they were in place; for example, specific staff training and care interventions. However, as noted under regulation 15, the risk assessment related to staffing required further assessment to ensure that it considered all potential impacts on residents and identified all relevant control measures.

There were good arrangements for the reporting, management and review of incidents. Inspectors reviewed the reported incidents in 2025. They found that the incidents had been escalated to the relevant parties, and had been reviewed to

identify potential learning to reduce the likelihood of the incidents recurring. The person in charge maintained a log of the incidents, and they were discussed at team meetings, management meetings, and noted in quality and safety reports.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that residents' health, personal and social care needs had been assessed to inform the development of associated care plans. However, one resident's specific health care plan required improvement.

Inspectors reviewed a sample of all four residents' assessments and care plans. They were found to be up to date, and readily available to inform staff practice. The plans related to residents' health, behaviour, communication, intimate care, social goals, safety and wellbeing. They reflected input from a wide range of multidisciplinary team services, including psychiatry, speech and language therapy, and occupational therapy. The plans also included important information on residents' interests, personalities, and preferences.

Inspectors found that one resident's specific health care plan required further review and cohesion to ensure that it outlined all associated interventions for staff to be aware of.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. Staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns, and there was guidance for them in the centre to refer to.

Inspectors reviewed the records of the most recent safeguarding concern, reported in 2025, and found that it had been appropriately reported and managed to promote the residents' safety.

The person in charge had ensured that intimate care plans had been prepared to guide staff in delivering care to residents in a manner that respected their dignity and bodily integrity. Inspectors reviewed all resident's intimate care plans and found that they were up to date and readily available to staff to guide their practice.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Oak Hill OSV-0007954

Inspection ID: MON-0049253

Date of inspection: 13/01/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staff team, PIC, PPIM and Health & Safety Officer have completed a risk assessment for times throughout day when staff are lone working in Oakhill, protocol also in place. This was discussed at team meeting held 13th January and will be for further discussion at next team meeting. Risk assessment updated 4th February to include service user experience being affected by inadequate resources. Staff to begin capturing negative service user experience due to inadequate staffing levels and complete relevant data. Newly revised risk assessment and protocol emailed to all staff on 6th February. An updated business case has been resubmitted to HSE on the 13th of February & we currently are awaiting approval. In the interim the provider has allocated an additional 24hrs staff support throughout the week to afford residents 2:1 support in the home while fellow residents access community living. Effective from 23rd February 2026. PIC continues to roster extra staff for scheduled activities such as concerts or individual goals. Oakhill's rosters will again be reviewed to ensure they are working as effectively as possible. The person in charge has ensured that there is a planned and actual staff rota, showing staff on duty during the day and night and it is also properly maintained.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

Staff team, PIC, PPIM and Health & Safety Officer have completed a risk assessment for times throughout day when staff are lone working in Oakhill, protocol also in place. This was discussed at team meeting held 13th January and will be for further discussion at next team meeting. Risk assessment updated 4th February to include service user experience being affected by inadequate resources. Staff to begin capturing negative service user experience due to inadequate staffing levels and complete relevant data.

An updated business case has been resubmitted to HSE on the 13th of February & we currently are awaiting approval. In the interim the provider has allocated an additional 24hrs staff support throughout the week to afford residents 2:1 support in the home while fellow residents access community living. Effective from 23rd February 2026.

PIC continues to roster extra staff for scheduled activities such as concerts or individual goals. Oakhill's rosters will again be reviewed to ensure they are working as effectively as possible.

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:
Residents had a recent procedure carried out in Our Lady of Lourdes Hospital on 30th January. Plan is now reviewed with oversight from CNM2 in Health & Chronic Disease Management. All necessary information and interventions are captured in the relevant plan of care. OLOL Dietician visited Oakhill on 5th February to provide further information on care and appropriate training provided by a Dietician from OLOL Hospital on 16th February. Dietician advised they can return to Oakhill to carry out 3-6 monthly procedure in residents' home to avoid any future, potential distress in a hospital environment.

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.	Not Compliant	Orange	23/02/2026
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	01/02/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery	Substantially Compliant	Yellow	23/02/2026

	of care and support in accordance with the statement of purpose.			
Regulation 05(6)(d)	The person in charge shall 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.	Substantially Compliant	Yellow	24/02/2026