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:	47/48 Towerview
Name of provider:	Health Service Executive
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	01 December 2025
Centre ID:	OSV-0005397
Fieldwork ID:	MON-0048499

About the designated centre

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

Towerview offers full-time residential care for up to seven female residents with an intellectual disabilities. The residents are supported twenty-four hours by a team of staff nurses and care assistants. The centre comprises two adjoined two-storey semi-detached houses and an attached one-storey, two-bedroom apartment. Both houses have three bedrooms, one kitchen/dining room, one sitting room and one small office and bathroom. The apartment contains two bedrooms, one sitting room/kitchen, one utility room and one bathroom. The houses are situated in a quiet residential centre close to the local town. Residents have access to local restaurants, cafes and shopping centres.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Monday 1 December 2025	11:10hrs to 20:50hrs	Karena Butler	Lead
Monday 1 December 2025	11:10hrs to 20:50hrs	Sarah Guing	Support

What residents told us and what inspectors observed

On the day of this unannounced monitoring inspection, the inspectors found a warm and positive atmosphere where the residents were receiving a good standard of person-centered care in their home. They appeared relaxed and comfortable in the company of a staff team who were patient and understood their individual needs.

While in the main good practice was observed and residents enjoyed a good quality of life, improvements were required particularly in relation to governance and oversight to ensure audits were meaningful and robust, and management systems respond quickly and appropriately to identified risks, such as broken fire doors. The quality of care plans required review to ensure all plans appropriately guide staff with accurate and applicable information. Other improvements required related to the statement of purpose and function for the centre, staff training, premises, and fire precautions. Furthermore, while residents were happy in their current home, inspectors identified that upcoming planned transfers for some residents may not fully uphold their rights or personal preferences regarding where and whom they live with. These matters will be further discussed later in this report.

The inspectors had the opportunity to meet and observe all seven residents that were living in the centre. An inspector briefly met two residents who used alternative communication methods. While they did not verbally share their views, they appeared content and comfortable in the presence of staff.

The inspectors had the opportunity to speak more in-depth with the other five residents. All spoke highly of the staff team stating that they were nice and would help them when they needed help. They all believed that staff treated them nicely and spoke to them with respect. None of the five residents spoken with had any concerns and confirmed that if they had any concerns, they would tell a staff member. They all felt that they had choice in how they spent their day and what they ate. They commented that they liked the house they lived in and that they had chosen how their room looked. For example, two residents confirmed that they had chosen their own bed linen. All felt that they had enough storage for their personal belongings. While one bedroom was observed to be cluttered with personal belongings, the resident confirmed that it was their preference to have their room that way as they liked to see their personal items.

On the day of this inspection, the residents engaged in different activities of interest. For example, two residents in one house attended a session for up-cycling furniture and later one of those residents attended a beautician. The other resident went on many independent walks. One resident attended their paid employment followed by attending a health group. Another two residents attended appointments. Another resident appeared tired and relaxed in the centre watching television.

One resident had moved into the centre earlier in the year and confirmed they were really happy they moved in and got on well with their housemates. They told the

inspectors that they had visited the centre on different occasions before moving in. On the day of this inspection, this resident had played pool and once home they said they wanted to relax in the centre for the evening.

An inspector had the opportunity to speak with the five staff on duty, the local nurse manager, and towards the end of the inspection, the person in charge. Staff were observed to be person-centered, kind and gentle in their interactions with the residents. They demonstrated they were for the most part aware of support requirements for the residents.

The provider had arranged for staff to have training in human rights. A staff member spoken with explained how they had put that training into every day practice. They communicated that they felt the training had cemented what they already knew and believed that everyone should be treated equally and with respect. That residents should have daily choices.

The inspectors did not have the opportunity to speak with a family representative. However, an inspector read the feedback questionnaires returned by three family members in 2025 with regard to the service provided to their family members. Feedback returned was positive with one family representative commenting that they felt "always welcome to visit".

This centre was made up of two semi-detached houses and one of the houses had an apartment attached. The inspectors observed the centre to be tidy and for the most part clean however, some mildew was observed in one house in different areas. The three sitting rooms had a television for use as well as in bedrooms as per residents' preferences. Each resident had their own bedroom and they were decorated and laid out how they would like them. For example, one resident had pictures of tractors and another resident had personal artwork displayed. The residents had personal pictures displayed in different parts of their home.

There was a front garden mainly used for parking with some potted plants. The back garden was accessible to the residents and had a table and seating for use to relax in times of good weather.

At the time of this inspection there was one visiting protocol in place for families to give advance notice where possible; however, no visiting restrictions were in place. At the time of this inspection there were no vacancies.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This inspection was unannounced and was undertaken as part of an ongoing

monitoring of compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). This centre was last inspected in May 2023.

The findings of this inspection indicated that while the provider, person in charge, and staff team have the capability to deliver good quality, person-centred care, there were a number of improvements required to ensure the service provided was safe and effectively monitored.

The inspectors found from a review across a three month sample of rosters that there were sufficient staffing in place at the time of this inspection to meet the needs of the residents.

The provider had ensured that for the most part, staff had access to appropriate and necessary training in order to effectively support the residents. Some improvement was required to the maintenance of the training oversight document and some staff required some training. For example, with regard to standard and transmission based precautions.

The provider had sufficient arrangements in place for the management of complaints. There had been a low level of complaints in the centre and any complaints made had been suitably recorded, reviewed and resolved.

Regulation 15: Staffing

The inspector found that the staffing arrangements in the centre were sufficient in meeting the current residents' assessed needs.

An inspector reviewed a sample of the rosters across September to November 2025. There were planned and actual rosters in place as required. The review demonstrated to the inspector that the provider had ensured that safe minimum staffing levels were maintained in line with what the provider had determined to be appropriate for the assessed needs of the residents.

While there was not a full staffing complement in place with the provider requiring three staff vacancies to be filled, consistent agency staff were found to fill any required shifts in the centre. This facilitated consistency and continuity of care.

The staff on duty on the day of the inspection were observed to be caring and respectful towards the residents. For example, a staff member was observed getting a blanket and scarf for a resident for an outing to ensure they would not get cold.

An inspector reviewed one staff personnel file, which included a police clearance certificate. In addition, a sample of Garda Síochána (police) vetting (GV) certificates for three staff members, three agency staff, and three external professionals, such as a person linked to the share a break group. All GV were completed in line with

best practice time frames. This demonstrated that the provider had arrangements for safe recruitment practices.

Judgment: Compliant

Regulation 16: Training and staff development

For the most part, there were suitable arrangements in place to ensure staff had appropriate training; however, gaps in the maintenance of training records meant the provider could not fully evidence that all staff were up-to-date with resident-specific training. In addition, while the majority of the staff team had all the necessary training to support the residents, some staff required certain training.

An inspector reviewed a sample of the certificates for four training courses for all staff as well as reviewing the training oversight document. While there was a training matrix in place some improvement was required as to how it was maintained to ensure accuracy of the information. For example, two staff were found to be present on the matrix who no longer worked in the centre, meaning the inspectors were not fully assured that the document was subject to regular oversight to ensure accuracy. In addition, as some training was not included in the matrix, it was difficult for management to maintain oversight of staff training needs. Consequently, the provider could not fully assure that all staff had appropriate training to meet the residents' needs.

The training matrix indicated gaps where staff training had expired or had not been completed. For example:

- it was not evident if staff were trained with regard to standard and transmission based precautions
- it was not evident if staff were trained with regard to cough etiquette and respiratory hygiene
- it was not evident if three staff had epilepsy training
- the matrix did not record if staff were trained in the administration of emergency epilepsy medication, the local manager confirmed staff were trained and that this was a documentation error
- one staff required refresher training in personal protective equipment (PPE)
- two staff did not have training related to feeding, eating or drinking (FEDs) and the centre supported two residents that had FEDs support needs.

Some examples of the training staff had completed included:

- safeguarding vulnerable adults
- training related to positive behaviour supports that included de-escalation techniques
- open disclosures
- people moving and handling

- medication management
- hand hygiene
- fire safety.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in 'what residents told us and what inspectors observed' section of the report.

From a review of three staff supervision records, formal supervision was occurring in line with the frequency decided by the provider. From speaking with a staff member, they confirmed to an inspector that supervision was occurring as required and that it was an opportunity to raise concerns if any.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that a number of improvements were required to the governance and management systems in place at the time of this inspection. The key issues related to the quality of the provider's auditing and oversight systems, and responding in a timely manner to identified risks. Therefore, this regulation was found to be not compliant.

An inspector found that certain fire containment doors had been identified in staff safety checks as not closing properly on different occasions in 2025. While all doors tested on this inspection were found to close, there were significant delays in getting the doors fixed when issues were identified. An inspector observed that fire containment doors malfunctioned on several occasions during 2025. Repairs took between three to six weeks to complete, leaving fire safety containment systems compromised for approximately three months of the year. This demonstrated that identified risks were not being responded to appropriately and would put the residents at risk from fire and smoke in the event of an emergency.

The provider's auditing systems were not operating effectively. An inspector found that while there was a schedule of audits due for completion in 2025, not all audits were being completed as per the schedule meaning that the document to guide auditors could not be fully relied upon. One inspector found that audits were not sufficiently robust as they failed to identify the issues identified on this inspection. For example, one inspector found that three bins were obstructing a critical escape route required for the evacuation of two residents if the use of a ski sheet was required.

A care planning audit reviewed sought to check if the plans were in place and completed in full. They did not check the quality of the care plans. An inspector found that care plans required improvements to ensure the quality of the information provided and to ensure there was no vague information. This will be

further discussed under the associated regulation.

Some audits appeared to be a 'tick-box' exercise; as in some cases the auditors were not required to provide examples or evidence to verify that a thorough review had taken place. The inspector found that in the case of the infection prevention and control (IPC) audit it contained aspects for review by the auditor that were no longer applicable. For example, that visitors were to complete a visitor declaration form and it was observed that the auditors for several audits in 2025 were selecting 'yes' for this which demonstrated to the inspectors that the audits were not always a meaningful review of the service.

It was communicated to an inspector that team meetings were due to take place every two months. An inspector found evidence of only three meetings occurring in 2025 with the last one being May 2025. It was not evident from reviewing the minutes of the January, March and May meetings if incidents were discussed and learning identified was shared with the staff team to promote consistency of approach and minimise the chances of those incidents reoccurring.

There were unannounced six-monthly provider visits completed in December 2024 and June 2025. There was an annual review of the service completed for 2024. While some family consultation was evident from one six monthly provider led visit in 2024, it was not evident if the views of residents were sought in 2024 or that they were consulted for the annual review as required by the regulations.

While all staff spoken with felt comfortable raising concerns with the local nurse manager if any were to arise, these systemic failures identified by the inspector demonstrate that the overall governance and management systems require significant improvement to ensure consistent oversight and safety.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose (SOP) and it had been reviewed within the last year. However, it was found to require further review as some information was incorrect or missing.

For example:

- the SOP described the centre as being able to cater for seven females and this was incorrect as a male was living in the centre
- while the local manager was on the organisational structure diagram, it was not evident from the diagram that staff were to report into them
- the person in charge was not present on the staffing table and their whole time equivalent was not recorded as to how much time they were dedicating to this centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy, and associated procedures in place. An accessible version of the policy was available for residents, and a copy of the complaints policy was available in the centre having been last reviewed in February 2024. There was also a designated complaints officer nominated.

One inspector observed any complaints made had been suitably recorded, reviewed and attempts were made to resolve any identified issues. From a review of the complaints log and associated paperwork, the inspector observed that there were two complaints in 2025. The complaints were found to be closed off to the satisfaction of the complainants.

Judgment: Compliant

Quality and safety

Overall, this inspection found that the residents living in this service were supported in line with their assessed needs. However, improvements were required with regard to care plans, resident's rights, the premises, and fire precautions.

Improvement was required to residents care plans to ensure all pertinent information was contained so as to appropriately guide staff. This in turn would ensure that residents were supported as per their assessed needs.

While each house and apartment was found to be homely and tidy, some mildew was identified in one house in several areas. Some painting and repairs were also required, such as some broken gutters. Improvement was also required in ensuring required cleaning equipment was used according to the provider's guidance and to ensure they were stored appropriately.

There were adequate systems in place to meet the requirements of the regulations associated with: communication, and general welfare and development. For example, staff were familiar with the communication methods of residents. Residents communicated that they had access to opportunities for recreation in line with their preferences.

There were suitable arrangements in place to ensure residents were safeguarded. For example, staff were suitably trained to recognise and escalate any safeguarding concerns.

While there were a number of suitable fire safety management systems in place, such as periodic fire practice drills, some improvements to certain aspects of fire safety were required. For example, ensuring that residents could be evacuated from all evacuation routes if required.

Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences.

One resident had been assessed by a speech and language therapist in May 2025 in order to assess if further supports could be provided to facilitate the resident's communication and recommendations made, which a staff member was familiar with.

From a review of three residents' files they had documented communication guidance in order to support staff to better understand and facilitate communication in a manner suitable for the residents. For example, information on communication to guide staff was included in various care plans to help support residents' understanding and ability to be understood. While some plans required further information or elaboration of the information provided, this information was known to the familiar staff team. Therefore, alternatively this will be actioned under Regulation 5: Individual assessment and personal plan.

From speaking with a staff member, they came across as very familiar with the communication supports required for the residents and how to be an effective communication partner for a particular resident.

In addition, the provider had arranged for the staff team to receive training in communicating with people with an intellectual disability.

The inspector also observed that residents had access to radio, televisions and the Internet while in the centre which would further support their communication and facilitate compliance with this regulation.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access to opportunities for leisure and recreation. Residents engaged in activities of interest in their home and community and were supported to maintain relationships with family. As previously stated, a family representative stated in the provider's feedback questionnaire that they felt welcome to visit the centre.

Residents were supported to set and achieve personal goals in order to enhance their quality of life. For example, from a review of a sample of three different residents' goals, they were undertaking goals related to attending a healing mass, visiting their family's original hometown, and attending a specific country house and estate for a day trip. The second resident wanted to join a knitting club and organise a milestone birthday of theirs that was coming up. The third resident wanted to source a part time cleaning job.

From a review of the two residents' activity logs from a week in November 2025, the inspectors observed that residents were participating in activities that interested them. Ranging from going out for food, bowling, reflexology, visiting family, shopping, and going for drives. Five residents confirmed that they get offered choice in relation to their activities.

While the recording of activities required improvement to ensure all applicable information was captured, the local manager had already self-identified this and had a plan to support the staff team to improve on their record keeping.

Judgment: Compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs. While the premises was found for the most part to be in a state of good repair and for the most part clean, some issues were identified and therefore this regulation was found to be substantially compliant.

While there was a colour coded system in place for the cleaning of the centre, not all colour coded cloths were available for use as per the provider's guidance. In addition, mop handles were stored outside exposed to the elements potentially affecting their cleanliness. An inspector also observed the cleaning buckets to have some dirt or debris in them. A staff member spoken with communicated that the system for the colour coding had recently changed and they were not familiar with the new system. Therefore, the inspector was not assured that the system in place was effectively working or monitored which could increase the chances of residents receiving a healthcare related illness.

There were some areas requiring attention, for example in one house mildew was observed around the windows of two resident bedrooms, the staff office, and the dining room window. Slight mildew was also observed around the silicone where the shower tiles meet the shower tray. This could negatively impact on residents' respiratory health.

The back and side of the house and some external windowsills required painting. The inspector was informed that the works would be going out for tender in January and therefore at the time of this inspection there was no set date for completion of those works. Two gutters were leaking and some gutters were observed to require

cleaning as were full with moss or debris. One area of the fascia was broken, which was self-identified by the provider. While the inspector was assured that repairs to the gutters, fascia, and mildew cleaning would be completed the following day, no evidence was submitted post-inspection to confirm these works were carried out.

Each resident had their own bedroom with sufficient space for their belongings. Bedrooms were observed to be individually decorated or set out to suit their preferences or needs. For example, one resident had displayed lots of soft cuddly toys.

The houses appeared homely and lots of personal pictures were displayed in different areas. Five residents stated that they liked living in their home. There was a front garden mainly used for parking. The back garden had garden furniture available for both houses for residents to sit out in times of good weather.

The facilities of Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities.

There were facilities in place to support hand hygiene, such as in the main bathrooms hand wash and disposable towels were available.

Overall, while the residents were comfortable in their home and the houses were found to be tidy, some improvements were required in order to ensure cleaning equipment was maintained in a hygienic manner and readily available as well as some works to be completed to ensure that externally the houses were aesthetically and functionally maintained, and that one premises was fully clean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were many suitable fire safety management systems in place, including detection and alert systems, emergency lighting and firefighting equipment, each of which was regularly serviced. However, some improvements were required with regard to fire evacuation.

An inspector found that staff had received training in fire safety.

A review of two residents' personal emergency evacuation plans (PEEPs) demonstrated to the inspector that there were fire evacuation plans in place for residents in order to guide staff as to evacuation supports required in the event of an emergency. The PEEPs could be enhanced further to ensure staff were fully guided as to what type of evacuation was the preferred method. This is being actioned under Regulation 5: Individual assessment and personal plan.

From a review of five drill records, the inspector found that a drill was completed during hours of darkness with maximum residents and minimum staffing

participating. However, there was no evidence to suggest that alternative doors were being used for evacuation as part of the practice drills in order to assure the provider that residents could be evacuated from all areas of the building if required. This was important in order to ensure that the residents would be familiar and comfortable in how to evacuate safely from whatever evacuation route was available in the event of an emergency.

An inspector observed that there were fire containment doors in place and they were fitted with self-closing devices. The inspector tested the majority of the doors and found that they closed fully by themselves. This would help prevent the spread of fire throughout the centre in the case of an emergency.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

An inspector found that there were suitable arrangements in place with regard to the receipt and storage of medicines.

The centre nurses ordered what medication was needed each month from the pharmacy. A medications stock check was completed upon receipt of medication into the centre and when it was being removed from the centre, for example for family visits. The inspector found that when medicines were returned to the pharmacy that a returns form was completed and signed by the pharmacist.

Medication was found to be stored in a locked press. The inspector reviewed a sample of one resident's medications and found that there were pharmacy labels attached and there was a description sheet in place for what each medication should look like for medication that was in blister pack systems to help prevent potential drug errors. Medication with a shorter shelf life once opened had a recorded date of when opened.

From a review of the medication documentation for two residents, this confirmed that residents had a medication administration kardex in place signed by the GP within the last six months.

Medication on the controlled drugs list was found to be locked in a press within a locked press as required. There was also a controlled drugs log with two nurses signing for the medication when administered and ensuring the stock count was correct. The inspector counted that medication in the presence of the nurse and found the count to match what was recorded on the log.

From a review of two medication audit records, the inspector found there were periodic stock counts occurring for medicines to be used only when needed. This was in order to ensure accuracy of stock and identify potential medication errors.

The systems in place supported safe medicines management, ensuring residents

received the correct medicines intended for them.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

An inspector found that while residents were receiving care in line with their assessed needs or recommendations, support and personal plans required significant review. Therefore, this regulation was found to be not compliant.

Care and support plans were found to be incomplete and had the potential for care not to be provided in line with the residents' assessed needs. The inspector found that plans sometimes lacked important information needed to guide staff and ensure residents' safety.

For example:

- a care plan for type 2 diabetes did not state what the resident's normal ranges were, or the signs of high or low blood sugar for staff to monitor
- an intimate care plan did not state the amount of staff required to support the resident and they required 2-1 support. It did not mention that they used a hoist and therefore that missing information had the potential to put the resident at risk of receiving care not in line with their assessed needs
- a hospital passport reviewed contained out-of-date information stating a resident had last received their COVID-19 vaccine in 2022, the local manager confirmed it was inaccurate stating that the resident had received a booster in 2025
- two residents' PEEPs were not specific in guidance as to what evacuation method was to be the preferred method for staff to follow
- on some plans the inspector observed that residents' names were not recorded and if the plan was removed from the resident's folder, unfamiliar staff would not know who the guidance related to, creating a risk of inconsistent care.

Some communication plans were limited in the information provided, for example staff explained that the resident could answer closed questions with a yes or no answer; however, this was not described in their plan. The plan stated that the resident could answer open questions; however, a staff member said that was no longer applicable. It was not evident from their plan how to know when they were happy or sad.

In addition, one resident’s epilepsy plan and emergency epilepsy medication protocol were found not to be reviewed within the last year. Therefore, in the absence of the review it was unknown if the information was still accurate and applicable.

A staff member spoken with, while they were familiar with a lot of applicable

information, had some gaps in their knowledge of certain supports residents may require with regard to diabetes or epilepsy.

An inspector also found that staff were not always recording in line with the prescribed frequency described by the provider, if a required cleaning task was completed for a blood glucose monitor or sleep apnea machine. An inspector found a number of gaps in the document whereby the equipment should have been cleaned. This had the potential to put residents at risk of healthcare related illnesses.

While staff spoken with were for the most part verbally familiar with residents' needs, the quality of the written plans was not sufficient to ensure safe, consistent, and person-centred care. The documentation failed to provide a reliable and comprehensive guide for all staff, particularly regarding critical health needs and risk management.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported with their healthcare needs and had access to allied health professionals when required.

Residents were found to have access to a range of allied health care services, such as a general practitioner (G.P), psychiatrist, sleep clinic, chiropodist, and oncologist when required.

There was evidence to support that residents were facilitated to avail of national screening tests when they were deemed eligible. For example, bowel screening and breast checks. In addition, an inspector found that residents were supported to receive vaccines, such as COVID-19 and or flu.

There were plans in place to guide staff as to what supports residents required with their healthcare needs. While some healthcare plans required review or more elaboration, this was actioned under Regulation 5: Individual assessment and personal plan.

Judgment: Compliant

Regulation 8: Protection

There were suitable arrangements in place to protect the residents from the risk of abuse. For example:

- there was an organisational safeguarding policy in place which was last reviewed September 2024
- staff had received training in safeguarding vulnerable adults
- there was a reporting system in place with a designated officer (DO) nominated for the organisation
- the identity of the DO was displayed in the halls.

The inspector reviewed safeguarding incidents since the last inspection and found that any potential safeguarding risks were escalated, reviewed, and reported to the relevant statutory agencies. There were safeguarding plans in place to minimise the chances of re occurrence of incidents. This demonstrated that safeguarding matters were taken seriously and investigated as required.

All five staff spoken with felt comfortable raising concerns to the local manager. At the time of this inspection, neither residents nor the staff members spoken with had any concerns. Five residents communicated that they felt safe living in the centre.

Two staff members spoken with were familiar with the steps to take should a safeguarding concern arise including a witnessed peer to peer incident or an unwitnessed disclosure.

An inspector reviewed the finance balance recording sheets for one month for two residents and found that the residents' money was being checked daily by staff to ensure their money was safeguarded. The inspector counted the money balance belonging to one resident in the presence of the local manager, and the amount was found to match that recorded on the finance recording sheet, demonstrating that the system for oversight was working effectively.

From a review of the two residents' files, the inspector observed that there were care plans in place that outlined residents' support needs and preferences with regard to the provision of intimate care in order to promote dignified care practices. While some information provided could be elaborated on in order to ensure consistency of staff approach, this was actioned under Regulation 5: Individual assessment and personal plan.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors were made aware that two residents were due to be discharged to other centres run by the provider. Those moves had a goal end date of 12 January 2026. While some rationale was provided as to why the moves would suit the residents, the inspectors were not assured that the moves had been appropriately assessed and deemed in the best interests of the residents. Therefore, this regulation was found to be substantially compliant.

The two residents had lived together for over 30 years. If the moves were to go

ahead the residents would no longer live together as two separate centres were identified for them. The proposed separation of these residents, after three decades of living together, risked negatively impacting their emotional wellbeing and social continuity.

An inspector requested relevant assessments and evidence outlining the rationale for these moves; however, no assessments were provided. Minutes of meetings were presented to an inspector whereby members of senior management had met to discuss the moves and what steps were required to facilitate the moves.

From reviewing the minutes and discussions with the local manager and person in charge, rationale given was that the houses the residents were moving to were bungalows and that they knew some of the staff and residents in the other centres. One proposed centre was located within a short drive from some family members and the other centre was located close to a church which it was communicated that the resident would appreciate. The inspectors were made aware that the residents' health and mobility was declining. The inspectors were informed that there was more nursing support in the other proposed centres.

The provider had already identified a resident to move into this centre instead of the two residents.

An inspector found that there was appropriate equipment found to be in place in this current centre to support the residents, such as a ceiling hoist. There was also a nurse on duty 24 hours a day.

It was communicated to the inspectors that the house where the residents lived was never meant to support people with higher dependency needs and would be better suited to more semi-independent living. However, the provider's statement of purpose for the centre had identified that the house in which the two residents lived could support high dependency needs, medical issues, and dementia. Therefore, the inspectors were not assured by the information presented that the moves were deemed to be in the best interests of the residents.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for 47/48 Towerview OSV-0005397

Inspection ID: MON-0048499

Date of inspection: 01/12/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The training matrix will be fully reviewed and updated to reflect all the required training including standard and transmission-based precautions, cough etiquette and respiratory hygiene, epilepsy and emergency epilepsy training, personal protective equipment and training related to feeding, eating and drinking. The CNM2 will commence a monthly monitoring system to be included with the monthly audits and ensure oversight of the staff training to ensure the matrix is up to date and oversight systems ensure a planned approach to scheduling both renewal of mandatory and professional development training. A supervision schedule will be maintained and checked monthly to ensure staff are receiving their required supervision supports.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Risk assessments in relation to fire safety including any identified issues has been reviewed to ensure senior management is notified of same if not rectified in a timely manner. Maintenance manager has been updated in relation to responding efficiently to risks presented. The fire safety checks will be reviewed to include the checks of designated escapes routes to ensure staff are clear on the required standards.	

Where hazards are identified to include fire containment the risk management policy escalation process will be adhered to and the matter escalated via the line management structure to ensure timely and responsive action.

The system for oversight and management to ensure the quality and safety of care will be reviewed and updated. In the interim period the frequency of visits to the Centre by the ADON will be increased.

The audits in place will be reviewed to ensure there is a more focused assessment on qualitative factors within the audit criteria and a more in depth assessment approach is in place to evaluate the quality and safety of care.

The audit schedule will be monitored by the ADON to ensure the audit frequency is maintained and audits are completed in full with corrective actions identified, assigned to an accountable person and managed until successfully addressed. This will be overseen by the ADON

An agreed schedule of team meetings will be implemented and minutes from the meetings provided to the staff team to share learning and to ensure a standardized approach in line with the policies of the service.

Future annual reviews and 6 monthly provider-led visits will include feedback from residents and/or their nominated representative.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose has been amended and includes the correct information regarding the residents, i.e. 6 females and 1 male.

The organizational structure diagram has been amended to include the correct reporting structure. The person in charge has been added to the staffing table and includes the whole-time equivalent hours spent dedicated to the centre.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The cleaning systems will be reviewed and guidance on the colour coding will be communicated with all staff to ensure they are familiar with the system. The storage of the cleaning equipment will be reviewed to ensure all equipment is stored inside and not exposed to the elements. The ordering of cloths and all cleaning equipment has been prioritized with the stores to ensure an adequate supply at all times to include colour coded cloths in line with the cleaning procedures in place

The frequency of cleaning audits will be increased and monitored by the CNM2 to ensure hygienic standards of cleanliness are maintained.

The HSE maintenance will complete the external works to ensure the aesthetics and of

the premises is well maintained. The required external painting requirements will go out to tender in January and will be completed, weather permitting in a timely manner. Maintenance have advised that it is better to wait until weather improves for external painting to be completed

Leaking gutters were repaired, all guttering was cleaned and the broken fascia was replaced on 02.12.2025.

All mildew has been cleaned from around the windows and the silicone seal in the shower tray replaced with a new sealant. Specialist contract cleaners have been contacted to complete deep clean for mildew, this will be completed by 31.01.2026

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The CNM2 has updated the resident personal emergency evacuation plans to include the preferred method and type of evacuation required for each individual resident to ensure the staff have clearly defined guidance on evacuation methods.

The fire drill documentation will include greater details on the specific evacuation routes. Fire drills will be completed to simulate evacuation through the various escape routes available within the Centre to ensure that staff are competent and familiar with evacuating residents from all parts of the building.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A full review of all individual and personal plans will be completed to ensure that all residents have an up-to-date, person-centred personal plan. Each plan will clearly outline the resident's health, personal and social care needs and care plans will reflect the relevant and important information required to guide staff and ensure residents receive safe, quality care.

The full review of each residents' care plans and support plans will ensure plans of care are evidenced based and accurately describe and sufficiently detail their current required care interventions based on their assessed needs with a particular focus on their healthcare needs. The CNM2 will ensure all protocols are reviewed and accurate information is maintained.
This will be included in the monthly audits and the audits will include corrective actions for each key nurse assigned responsibility for care plan updates and reviews

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A further more detailed comprehensive review of any proposed move by two residents will be completed taking full account of the will and preference of both residents.

Residents and or their nominated representatives will be supported with all relevant information to include advocacy support if requested.

Environment and compatibility assessments will be undertaken. Multi-disciplinary teams will be included in the decision-making process to ensure the best interest of each resident is upheld in line with their capacity and preference for any future living arrangements.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/01/2026
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 objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/01/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	28/02/2026

	state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/01/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	19/12/2025
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	05/12/2025
Regulation 05(6)(a)	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 be multidisciplinary.	Not Compliant	Orange	30/01/2026

Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Not Compliant	Orange	30/01/2026
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.	Not Compliant	Orange	30/01/2026
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	16/01/2026