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:	Goldfinch 5
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Announced
Date of inspection:	17 July 2025
Centre ID:	OSV-0007711
Fieldwork ID:	MON-0039090

About the designated centre

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

Goldfinch 5 is a ground floor duplex apartment located in a housing estate in a city. It provides a full-time residential service for up to four female residents, over the age of 18 with intellectual disabilities and those with physical or mobility support needs. Each resident in the centre has their own bedroom and other rooms provided includes a sitting room, a living room, a kitchen, a laundry room, bathrooms and staff bedroom/office. Residents are supported by the person in charge, social care workers and care assistants by day and a sleep –over staff at night time

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 17 July 2025	10:30hrs to 17:30hrs	Elaine McKeown	Lead

What residents told us and what inspectors observed

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to inform the decision in relation to renewing the registration of the designated centre. The centre was previously inspected in August 2022 as part of the current registration cycle. The provider had addressed all of the actions identified during that inspection which included the installation of new storage facilities in the designated centre and ongoing engagement with primary care teams as required by the current residents in the designated centre.

There were three residents in receipt of residential services in this designated centre at the time of this inspection. On arrival the inspector met with the person in charge and was aware that two of residents would meet with the inspector in the afternoon on their return from their day service. The inspector was also aware one resident was away on a planned break with family members.

The inspector completed a walk around of the designated centre and reviewed documentation before speaking with the residents. The premises was found to be well ventilated, clean and displayed evidence of residents personal preferences and interests. There was evidence of ongoing maintenance taking place. The person in charge explained there had been a change in the residents in receipt of services since the previous inspection. Two residents were supported to transfer to other designated centres where their assessed needs could be better met. Following these transfers, the remaining two residents moved into the bigger bedrooms. Both residents were supported to redecorate their new bedrooms and reported to be very happy.

The access to the two rear garden areas was through the two large bedrooms. The inspector was informed the garden areas were not used very often. The inspector was aware previous residents had been consulted and given written consent for access to the rear garden areas when they occupied these rooms. However, the current residents who occupied these bedrooms had not been consulted or their consent obtained in the event that other residents or staff members may on occasions require to access the garden area through the bedrooms.

The newest resident to avail of residential services in the designated centre was admitted in August 2024. The resident was reported to have settled in well and their usual weekly routine was spent mid-week in the designated centre and the resident spent most weekends with family members. This resident had been supported with a request for a change to the bed that was in their bedroom to better suit their needs and the provider had addressed this to the satisfaction of the resident. The inspector was informed that the resident was planning on staying for a full week while their day services were closed during the Summer.

The inspector met with both of the residents on their return in the afternoon with a staff member. Once they had attended to their usual routine both residents were

offered the opportunity to speak with the inspector. One resident liked to watch preferred programmes in the afternoon in the sitting room and did engage briefly with the inspector. The resident indicated that they were happy with their home and bigger bedroom, felt safe in their home and could talk with staff if they had any concerns. The resident then wished to return to watching their programme and this was respected by the inspector.

The other resident wished to speak with the inspector and this was facilitated in another sitting room in the designated centre. The resident spoke of the issues they were encountering using the transport vehicle. They were finding it difficult to keep their balance getting on and off the vehicle. The resident had been supported to make a complaint about the issue and the inspector was given an update during the inspection regarding the matter by the management team. This will be further discussed in the capacity and capability section of this report.

The resident spoke positively about plans for an overnight stay in a hotel and attending a concert in August. They outlined how they were happy with their day service and how staff supported them in the designated centre. The resident spoke of missing a peer who had previously lived in the designated centre but had met with the person on a few occasions since. The resident outlined their preferred evening routine, their enjoyment of going shopping and how they were consulted in the running of the designated centre. The resident identified who they would speak to if they had any concerns and was happy being supported by the staff team with their finances. The resident also spoke about current medical issues and how they were awaiting an appointment to meet with a consultant. Following a review of this resident's prescribed medications by the inspector it was identified that one medication, which was required to be taken once a month was not being administered in-line with the manufacturer's guidelines. This will be further discussed in both sections of this report.

As the residents were out attending their day service for most of the inspection, there was only a small period of time that the inspector observed the residents engage with the staff present in the designated centre at the end of the inspection. Both residents appeared familiar with the staff present and were observed engaging in casual conversations about their day and plans for the weekend ahead. A staff member was observed to ensure each resident was still happy with the planned meal option and ensured each was supported to complete their preferred routine on return to the designated centre. The atmosphere was noted to be relaxed throughout. This included offering alternative space for one resident to speak with the inspector without impacting the other resident.

In summary, residents appeared to be happy with their home and the supports being provided to them to live in the community. The inspector was given completed resident questionnaires to review. All responses were documented as positive with a small number of additional comments regarding how a resident liked their home, bedroom and how visitors can have refreshments when they come to the house. One of the residents did comment on the food which at times they stated they didn't like. Progress updates were provided during the inspection in relation to a suitable transport vehicle being available for the residents. However, further improvements

were required regarding the oversight of the safe administration of medications. In addition, the use of the term "pocket money " when documenting the residents finances also required review.

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

Capacity and capability

Overall, this inspection found that residents were in receipt of care and support from a consistent staff team. Residents expressed concerns were evidenced to be addressed or in progress at the time of this inspection. The provider had adequately addressed all of the actions identified in the previous inspection that took place in August 2022, apart from one. Staff supervision was still not occurring in-line with the provider's policy

While there were systems in place to monitor the services being provided further review of the effectiveness of the medication audits that had taken place was required. The provider had a requirement in their medication policy for medication audits to be completed every quarter in the designated centre. This had not occurred consistently since the previous inspection. During 2024 such audits had occurred in March, August and December 2024. On the day of the inspection no medication audits were available for review for 2025. The audits completed that were reviewed by the inspector had not identified any issues by the provider relating to the prescribed medications for one resident and the safe administration of such medications. This will be further discussed in the quality and safety section of this report.

The provider was aware of the regulatory requirements to complete an annual review and internal provider led audits every six months in the designated centre. The inspector reviewed the annual review for the designated centre which was completed for the year 2024. One action relating to staff training was identified and ongoing review and progress was evident by the person in charge. Internal six monthly provider led audits were also completed in June and December 2024 and June 2025. There had been repeated findings related to Regulation 21: Records during 2024. The actions identified in the most recent six monthly audit completed in June 2025 where updated by the person in charge to reflect if completed or in progress. Actions identified included ensuring staff training was being scheduled and monitoring the impact on residents quality of life in relation to the transport vehicle. These were evidenced to be in progress during the inspection.

The provider had systems in place through which staff were recruited and trained, to ensure they were aware of their roles and responsibilities in supporting residents in the centre. Residents were supported by a core team of consistent staff members. During the inspection, the inspector observed kind, caring and respectful interactions between residents and staff. Residents were observed to appear comfortable and content in the presence of staff, and to seek them out for support as required. For example, discussions were held about the evening meal, each resident was afforded the time to respond and one resident was listened to by staff present when talking about a personal issue.

The provider had submitted an application to renew the registration of this designated centre which included planned changes to enhance the oversight and governance. The provider was seeking to add another property to the designated centre and increase the total number of residents being supported. This property and the current residents were already under the remit of the same person in charge. The property was not visited during this inspection but assurance regarding that property and the residents living there had been provided from another inspection completed recently in that property.

Registration Regulation 5: Application for registration or renewal of registration

The provider had ensured a complete application to renew the registration had been submitted as per regulatory requirements. Minor changes and clarifications to the statement of purpose and floor plans were discussed during the inspection with the provider required to submit the updated versions as part of the documents for review for the renewal of registration.

The provider had informed the Chief Inspector of the rationale to increase the overall footprint of this designated centre at the time of the renewal of registration to include an additional house under the remit of the same person in charge and management structure.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed to work full-time and that they held the necessary skills and qualifications to carry out their role. They demonstrated their ability to effectively manage the designated centre. They were familiar with the assessed needs of the residents and consistently communicated effectively with all parties including, residents and their family representatives, the staff team and management. Their remit was over this designated centre and one other designated centre located approximately five

minutes drive away at the time of this inspection. The provider had plans to reduce this remit to one designated centre with the re-structuring of this designated centre to include a house currently registered as a designated centre during the registration process. The person in charge was available to the staff team by phone when not present in the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that the number, qualifications and skill mix of the staff team was appropriate to the number and assessed needs of the residents and in line with the statement of purpose. There was a consistent core group of staff working in the designated centre.

- The staff team comprised of social care workers.
- There were no staff vacancies at the time of the inspection. The team were supported by regular relief staff who were familiar to the residents when there were gaps in the rosters due to planned training or leave.
- The person in charge had made available to the inspector actual rosters since 18 May 2025 and planned rosters until 27 July 2025, 10 weeks. These reflected changes made due to unplanned events/leave. The inspector was informed the final draft of each rota was the actual rota. The minimum staffing levels and skill mix were found to have been consistently maintained both by day and night. The details contained within the rosters included the start and end times of each shift and scheduled training.
- Details of when additional on-call staff resources were located in the designated centre were also reflected in the rota. This additional resource assisted residents to engage in individual activities if they wished to do so.

Judgment: Compliant

Regulation 16: Training and staff development

At the time of this inspection the staff team was comprised of eight members which included the person in charge, two social care workers and five relief staff. The relief staff group was comprised of both support workers and social care workers.

- All staff in the centre had completed a range of training courses to ensure they had the appropriate levels of knowledge and skills to best support residents. These included training in mandatory areas such as fire safety, medication management and safeguarding.

- The person in charge was aware there were some gaps in the training requirements of a number of staff. For example, two staff were booked to attend training in safety intervention in September 2025. Previous training that was scheduled for this course had to be cancelled due to circumstances outside of the provider's control.
- Meetings notes of three monthly staff meetings that had taken place since January 2025 were reviewed by the inspector. Five staff meetings had also taken place in 2024. Each meeting discussed safeguarding, complaints and updates on the residents in receipt of services in the designated centre. Actions arising out of these meetings were detailed with the person responsible and documented with the date when completed.
- The person in charge provided details of the dates supervision that had taken place with the staff team during 2023, 2024 and to date in 2025. The person in charge was aware that the frequency of supervisions was not occurring quarterly in -line with the provider's policy on staff supervision. From the details provided it was evident staff had been supported to have at least one supervision with the person in charge each year. Five of the current staff team had completed at least one supervision with the person in charge since January 2025.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The provider had ensured a directory of residents had been maintained within the designated centre. It was subject to regular review. The inspector was provided with information regarding the discharge dates of two residents to two other designated centres. The details pertaining to the most recent admission to the designated centre were found to be complete.

The directory included all of the information specified in paragraph (3) of Schedule 3

Judgment: Compliant

Regulation 22: Insurance

The registered provider had ensured that the designated centre was adequately insured. The current documentation was submitted by the provider as part of their application to renew the registration of the designated centre. The provider was advised during the inspection an updated certificate of insurance would be required to be submitted once issued by the insurer in October 2025.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place, with staff members reporting to the person in charge. The person in charge was also supported in their role by a senior managers. The provider had ensured the designated centre was subject to ongoing review to ensure it was resourced to provide effective delivery of care and support in accordance with the assessed needs of the residents and the statement of purpose.

The provider had governance and management systems in place to oversee and monitor the quality and safety of the care of residents in the centre. These included internal six monthly audits, a schedule of audits such as infection prevention control and monthly finance audits. However, further review of the current medication audits was required to ensure effective oversight. The current process had not identified an error that was occurring monthly since November 2022 for one resident. As a result of this finding the provider was requested to submit a provider assurance report to the Chief Inspector relating to the safe administration of such medications in all designated centres under the provider's remit.

A repeat finding since the previous inspection was also identified regarding the supervision of staff in-line with the provider's policy. Staff supervisions were not taking place quarterly. This will be actioned under Regulation 16: Staff training.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had taken steps to ensure all residents had an up-to-date contract of care in place. The contracts that were reviewed by the inspector were in the new format introduced by the provider. The inspector was informed that the signature of a provider representative on each contract was under review at the time of this inspection

The contracts were individual to each resident, outlined the services being provided and consistent with the assessed needs of the resident for whom the contract had been prepared.

A resident who had been supported to commence living in the designated centre in August 2024 was effectively supported to have a smooth transition. A person

centred transition plan was developed with the resident and their family representatives and the progress was documented in the same plan.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was subject to regular review. It reflected the services and facilities provided at the centre. The document had been updated to reflect the inclusion of another house in the footprint of the designated centre as part of the renewal of registration process. The document contained all the information required under Schedule 1 of the Regulations. An updated version was required to be submitted following the inspection to include revised floor plans.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that a written report had been provided to the Chief Inspector at the end of each quarter as required by the regulations. The reports submitted were reflective of changes to the residents in receipt of services in the designate centre.

The person in charge had ensured the Chief Inspector had been notified in writing within three working days of all adverse incidents. There was evidence of review and recommendations to reduce the risk of similar incidents occurring which included measures and controls in place to support residents in situations such as communal living and respecting peers.

A number of adverse interactions had also been documented as occurring since the last inspection. The inspector reviewed three of these such incidents. The rationale for these to be managed under the complaints procedure was documented. Residents were supported through their resident meetings and individual meetings to be provided with information regarding better communication techniques to avoid possible adverse impact on their peers.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had ensured residents were aware of the complaint process and supported to make complaints in the designated centre when issues arose that had an impact on them.

- Details of who the complaint officer was were observed to be available within the designated centre.
- There had been three complaints made during 2024 and two to date in 2025. One of the most recent complaints remained open at the time of this inspection
- Learning and recommendations had been documented following the complaints that had been made and resolved to the satisfaction of the complainant.
- One resident had complained about the size of their bedroom and was supported to move to a larger room that was vacant at that time.
- An open complaint regarding the suitability of the transport vehicle had been made by a resident in May 2025, the complaint was escalated as it could not be resolved locally. There was documented evidence of engagement with other departments and senior management to seek a resolution to the complaint. There was correspondence to the resident regarding the ongoing review of the issue by the provider. On the day of the inspection, an update was provided on a resolution to the complaint which the resident was to be informed of.

Judgment: Compliant

Quality and safety

Overall, residents' rights were being promoted, individuals were being encouraged to build their confidence and independence, and to explore different activities and experiences.

The staff team had systems in place including handovers to ensure staff were provided with up-to-date information while providing support to each of the residents. The staff spoken to during the inspection were aware of personal preferences and choices of each resident. They were observed to ensure residents were consulted and included in decision making, for example, with meal preparation, morning and evening routines . Where required residents were provided with time and space if they chose to not engage with the staff supporting them or the communal area became too noisy or busy for them.

The inspector was aware the provider was working towards a resolution regarding the management of two residents personal finances in this designated centre as well as in other designated centres under the provider's remit. While the person in

charge had outlined to the inspector that there were currently no issues relating to any resident accessing their finances, the terminology being used required further review. The meeting notes documented during residents meetings referred to the residents "pocket money" being requested from the provider. This was not terminology that was reflective of the adults about which the request was being made.

The person in charge, outlined limitations with the current staff resources and had encountered difficulties to support residents identify and progress personal goals. While residents were consulted in identifying goals during meetings, the extent of choice and opportunities was not clearly evident for all residents at the time of this inspection. The inspector acknowledges that all residents reported they were very happy living in the designated centre either verbally or in completed questionnaires. However, the progression of some identified goals for 2025 was unclear at the time of this inspection. For example, one resident had named two particular artists they would like to see in concert: however, there was no update or progress to date documented if these were going to be attained by the resident.

While residents were being supported by a community primary care team and had access to allied healthcare professionals to monitor and mange health care conditions, it was identified during the inspection that one resident who had been identified as being at risk of a degenerative bone condition may not have been effectively supported to manage that condition. The resident had been prescribed a once monthly medication since November 2022, according to documents reviewed by the inspector. There were specific administration guidelines required to be followed by staff when administrating the particular medication. These guidelines were not adhered to and the resident was reliant on the staff team to administer this medication correctly to ensure it was effective for the purpose for which it was being administered.

Regulation 10: Communication

The registered provider had ensured that each resident was assisted and supported to communicate in accordance with their assessed needs and wishes. This included ensuring access to documents in appropriate formats for a range of topics including fire safety, safeguarding, advocacy and consent.

Residents also had access to telephone, television and Internet services in line with their assessed needs. One resident had recently been supported to purchase their own mobile phone.

Both residents spoken with during the inspection were aware of the process of how to make a complaint and who they would speak with if they had any concerns. There were information leaflets available in the designated centre which included who the complaints officer was.

Judgment: Compliant

Regulation 11: Visits

The registered provider had ensured residents were supported to receive visitors in their home, if they wished to do so. There was ample communal space to provide each resident with privacy during such visits if required without impacting on their peers. The designated centre had two sitting rooms.

In addition, residents were supported to visit relatives regularly. One resident stayed with relatives each week and the inspector was informed by one of the residents they met during the inspection that they had a planned overnight visit scheduled for the weekend after the inspection which they were looking forward to.

Judgment: Compliant

Regulation 13: General welfare and development

The provider had ensured each resident was being supported with appropriate care and support. For example, residents were supported to engage in activities relating to their interests and hobbies. This included flower arranging and swimming activities.

Residents were being supported to engage in activities and training to further enhance their independence and skills knowledge in areas such such as cooking, shopping and using a mobile phone.

Residents were provided with their own personal space when required and personal relationships were maintained with friends, peers and relatives.

Judgment: Compliant

Regulation 17: Premises

Overall, the designated centre was found to be clean, well ventilated and comfortable. A choice of internal communal areas were available to all residents to use as they choose to do so. However, the access to the external rear garden areas was through two bedrooms. The use of this space required the consent of each resident in these bedrooms to be obtained. The inspector acknowledges that this

was not an issue at the time of the inspection but would be required to be considered in the event of a new admission to the designated centre and the third resident was present more frequently than their current routine of a few nights each week after attending day service.

- Bedrooms were decorated in line with personal preferences. Two bedrooms had their own en-suite facilities.
- Each resident had comfortable seating and the provision of tables to complete preferred activities in the bedroom if a resident choose to do so.
- Communal areas had ample comfortable seating to suit the assessed needs of the residents.
- The provider had addressed the actions identified in the August 2022 inspection, which included improved storage facilities in a number of areas in the designated centre.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had ensured residents were provided with a guide outlining the services and facilities provided in the designated centre in an appropriate format.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy which outlined the processes and procedures in place to identify, assess and ensure ongoing review of risk.

- There was one escalated risk at the time of this inspection relating to the transport vehicle available to the residents in the designated centre
- Individual risks had been subject to regular review. However, further review was required as the measures in place to mange particular risks were not reflective of the rating or in line with the provider's risk matrix. For example, all three residents were reported to evacuate in the event of a fire drill with verbal prompts. On some occasions in recent months two residents had evacuated without any staff prompting. However, this was not reflected in the current risk or control measures for each resident.

- One resident had been identified as being unsteady on their feet and at increased risk of falling in a complaint made by the resident in May 2025 but this was not reflected in the most recent review of the risk for the resident.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had protocols in place to monitor fire safety management systems which included weekly, monthly, quarterly and annual checks being completed.

- All residents had a personal emergency evacuation plan (PEEP) in place. These were subject to regular review and were reflective of the supports and prompts that may be required for each individual.
- No exits were observed to be obstructed during the inspection.
- The emergency evacuation plan had been subject to regular review and updated following the most recent admission of a resident to the designated centre.
- Regular fire drills had been completed with all of the residents, including minimal staffing drills. Fire drills documented senarios and the promptness of response by each resident. During the feedback the inspector informed those present that the resident who had been admitted in August 2024 was consistently located in the same room of the house when each drill had taken place and the exit being used by them was the same on each occasion. However, this exit would not be the closest exit to them if they were located in their bedroom when the fire alarm was activated.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured a medicine prescribed for a resident in November 2022 had been administered in line with the manufacturer's guidelines. The medication was prescribed to be administered to the resident once a month as part of a preventative measure for a degenerative bone condition. The efficacy of the medication being administered not in -line with the manufacturer's guidelines was unclear.

- While all staff had completed training in the safe administration of medications, it was not evident staff had read the printed information leaflet regarding the specific administration guidelines for the medication. This was available in the resident's personal folder and read by the inspector who

immediately noted the special requirements required to be taken when administering the medication.
- The dispensing of the medication by pharmacists since November 2022 had not highlighted the special requirements for administration of this medication.
- The provider's three internal medication audits that were completed during 2024 had not identified any issue relating to the incorrect dispensing or administration of the medication for the resident.

As a result of this finding the provider was required to provide an assurance report to the Chief Inspector regarding the safe administration and practices in place for the administration of infrequent medications to residents in receipt of residential services in all of the designated centres under the provider's remit.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed different sections of the personal plans of three of the residents during the inspection. All were found to be subject to regular review. The person in charge also completed regular reviews of each residents personal plan. Archiving of older documents was also taking place to ensure relevant information was available for the staff team.

- The profiles were found to be person centred, reflective of changes that had occurred for residents and provided up-to date information on supports required with activities of daily living and likes and dislikes.
- There was evidence of multi-disciplinary input to support residents assessed needs.
- The resident who had commenced availing of residential services in August 2024 in the designated centre had been supported to develop a person centre plan within a short time frame of admission.
- Residents had been supported to identify some goals that were meaningful to them such as attend flower arranging workshops. One resident had a documented goal of attending swimming. The inspector was informed the resident had returned to enjoying this activity in recent months in their day service, while it remained a goal at the time of this inspection it was discussed that regular participation in such activities would not be viewed as a personal goal if occurring frequently each week as in the case of this resident.
- However, the identification and progression of personal goals were reflective of available staff resources in the designated centre. For example, the inspector was informed that short breaks were limited to one night away, or concerts that were occurring in nearby locations. This will be actioned under Regulation 9: Residents rights

Judgment: Compliant

Regulation 6: Health care

The person in charge had ensured residents were being supported to access appropriate health information both within the designated centre and in the wider community to make informed choices, such as healthy eating.

- Each resident was subject to regular health checks in line with their expressed wishes.
- Residents were being supported in line with expressed wishes regarding screening programmes for which they were eligible to access. One resident had been supported to attend for a particular screening programme but indicated by their actions they did not consent at that time. Staff explained that further information will be provided to the resident and they will be supported to attend again in the future if they chose to do so.
- Residents were supported to attend a general practitioner of their own choice.
- Residents were being supported to avail of services as required from the primary care team.
- Residents were also supported to attend appointments with other allied healthcare professionals such as consultants as required. One resident was awaiting an appointment to meet with a consultant regarding an ongoing medical condition.

However, while staff were supporting residents to manage known health conditions, a particular medication to manage /prevent the progression of degenerative bone condition for one resident had not been administered correctly to the resident since November 2022. As this issue was identified on the day of the inspection, it is unclear if this has had an adverse impact for the resident.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were supported to experience the best possible mental health and to positively manage challenging issues. The provider ensured that all residents had access to appointments with health and social care professionals such as, psychiatry, psychology and behaviour support specialists as needed.

Residents who required behaviour support plans had these in place. There were systems in place and evidence of oversight by the person in charge to ensure regular review of these plans was occurring. The reviews ensured the specific plans were effective in supporting the assessed needs of the residents for whom they

were in place. One resident had a behaviour support plan in place and another resident had a protocol in place to best support their current assessed needs. There was evidence of staff being informed of how to support each resident to avail of personal space and de-escalate situations effectively.

Judgment: Compliant

Regulation 8: Protection

All staff had attended training in safeguarding of vulnerable adults. Safeguarding was also included regularly in staff and residents meetings to enable ongoing discussions and develop consistent practices.

- One safeguarding plan had been closed out by the safeguarding and protection team in June 2025. Actions and measures were in place to ensure the well being of the residents. It was discussed during the inspection from the documentation provided to the inspector to review, further details would be of benefit to be provided to the staff team, to minimise the risk of similar situations arising in the future.
- The personal and intimate care plans promoted the resident's rights to privacy and bodily integrity during these care routines. The residents had care plans in place that respected their independence in their own self care and outlined areas where support may be required at times.

The issue identified during the inspection relating to the incorrect monthly administration of a particular medication in line with the manufacturer's guidelines since November 2022 will be actioned under Regulation 23: Governance and management and Regulation 29: Medicines and pharmaceuticals.

Judgment: Compliant

Regulation 9: Residents' rights

In line with the statement of purpose for the centre, the inspector found that the staff team were striving to ensure the rights and diversity of residents were being respected and promoted in the centre.

- Residents were being supported to self advocate for themselves. For example, when a resident voiced a concern relating to a proposal for another resident to move into their home, this was given consideration by the staff team and the provider to ensure all parties were happy with the eventual outcome. The proposed new resident declined the offer to move into the house as they did not feel it met their needs.

- A resident who requested to change their general practitioner to one located closer to the designated centre was supported by the staff team and their family to do so.
- Where a resident had identified an issue with the suitability of the transport vehicle that was available to them, the staff team supported the resident to escalate the issue to senior management. The inspector was informed during the inspection that an alternative vehicle had been identified by the provider's transport department and would be made available to the residents in the weeks after this inspection.

However, during inspections completed in other designated centres operated by the registered provider, it was identified that residents' bank accounts were held with one banking organisation and that there was no evidence to support that the residents were involved to select a bank of their choosing, were consulted and had the freedom to exercise control in relation to this. During the inspection of this designated centre, it was indicated that matters related to two residents' bank accounts were consistent with this finding. For example, residents bank statements were going to the provider's administration building. The provider had completed a review of the "Policy on the handling of the personal assets of adults supported by the services". The provider completed a restrictive practice decision making record within the policy which acknowledged aspects of the policy are restrictive. The policy also references that restrictions were being kept to a minimum while endeavouring to ensure adequate arrangements were in place to protect resident's finances.

The inspector acknowledges that a pilot programme was being planned for residents in this designated centre regarding the management of personal finances. One resident was being supported by family members to manage their finances. The person in charge reported there were currently no issues regarding the residents accessing their finances. Monthly finance audits were being completed by the person in charge. However, the term "pocket money " was consistently documented in residents meeting note records. This terminology was not reflective of the adults about which the term was being used.

The person in charge informed the inspector that the location and frequency of residents' holidays and overnight stays had been restricted due to a lack of resources. Holidays and hotel breaks were restricted to one night. Management in the centre noted that there was a reliance on the 'goodwill' of staff members to support residents to go on holidays and overnight breaks. For example, a planned overnight stay and attending a concert in a tourist town in August for a resident was reliant on one particular staff member supporting the resident. Another resident had a goal to attend an advocacy conference in October 2025. The same resident had identified named artists which they would like to see in concert. While the resident had attended a concert by another artist in June 2025 it was unclear if their goals were going to be able to be progressed at the time of this inspection.

In addition, due to the design and layout of the building, access to the rear gardens was via the two large bedrooms at the rear of the property. Previous residents who had been in these bedrooms had been consulted and given consent in the event other residents or staff required to enter their bedrooms to access these areas. this

had not been considered to be discussed with the current residents in either of these two bedrooms.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Goldfinch 5 OSV-0007711

Inspection ID: MON-0039090

Date of inspection: 17/07/2025

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 Person in Charge will continue to monitor the training records of all staff working in the designated centre, including relief staff, to ensure that all staff training is kept up to date. The designated centre's training records are maintained in the form of a training matrix. • Going forward, the Person in Charge will ensure that support and supervision sessions are conducted with all staff members on a quarterly basis, which is in line with the provider's Support and Supervision policy.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • All medications are prescribed by a GP in line with residents' medical needs. This is the first safeguard to ensure safe administration of medication. The GP is knowledgeable of the medications individuals take and their potential interactions and contraindications. • All medications are dispensed by a pharmacist as instructed by the GP's prescription. The pharmacist is the second safeguard in the process, when dispensing. They can highlight concerns to the GP regarding prescription safety where this arises. • The pharmacist issues instructions at the time of dispensing advising of the safe administration of medication, including how to take the medication (before or after food, foods/ drinks to avoid). A patient information leaflet is also provided for each	

medication.
• Responsible and safe administration of medications (RSAMS) training is provided by the BOCSIL to all staff working in Community Services on commencement of employment to ensure the safety of all residents in relation to the safe administration of all medications, in line with organisation policies and best practice. This training includes three components, theoretical component, knowledge assessment and a number of competency assessments.
• The importance of following the guidelines issued by the pharmacy for all prescribed medicines is included in the medication training provided to staff. Individual medication are not covered during this training.
• Medication Audits are completed on quarterly basis by Area Manager or delegate in line with the BOCSILR medication policy. The scope of medication audits covers storage facilities, medication packaging, drug prescription and medication recording charts and medication delivery audit.
• The responsibility of staff, as set out in the Policy for the Administration and Management of Medication of the BOCSILR, is to follow the guidance set out in the kardex as prescribed by the GP and to observe and follow the administration instruction as per the pharmacy dispensing label and Patient information Leaflet. The staff of the service are to adhere to the Policy for the Administration and Management of Medication Process within BOCSI-LR in all aspects of medication management.
• The six month unannounced process reviews AIRS and medication errors as part of this oversight. The reviewers rely on the quarterly medication audits of the Area Manager to provide more detailed oversight.
• As a result of the findings from the inspector, the provider submitted a provider assurance report to the Chief Inspector. The findings as set out in the Provider Assurance Report will be shared in by the Head of QET to determine in consultation with Head of Community and Director of Services if further oversight is required.
• The Pharmacist has advised that they will issue a Patient Information Leaflet for each person supported on medication dispensed on the next rotation.
• A review of RSAMS training by the RSAMS trainers will take place to reinforce the importance of reading and being informed by the information contained in the Patient Information Leaflets, to all attendees during the initial training and refresher training. These guidance is included in existing training materials.
• The BOCSIRL Policy on the Management and Administration of Medication has been referred to the BOCSILR Policy review group in the context of the performance assurance report to determine if the policy requires a review. This will include a review of the audit template to ensure it covers this aspect of the policy. This will also include review of administration of medication prescribed intermittently.
• Administration of medication will be put on the agenda of staff meetings whereby staff will be reminded of their responsibility in the administration of medication include the importance of following patient information leaflet guidance.
• The BOCSILR is exploring the possibility of a pharmacist carrying out ad-hoc medication audits.
• All dispensing pharmacies for the BOCSILR will be contacted to provide assurance to the service that all administration guidelines relating to prescribed medications will be detailed on all pharmacy dispensed packaging.
• Director of Services, Head of Quality and Head of Community to review six month unannounced review template in the context of this finding.
• The learning from this finding will be on the agenda for the next Person in

Charge/Director of Services meeting on the 27th of August 2025.
• Going forward, the Person in Charge will ensure that support and supervision sessions are conducted with all staff members on a quarterly basis, which is in line with the provider's Support and Supervision policy.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The rating of the individual risk assessments in relation to residents evacuating the premises in the event of a fire have been reviewed and updated so that they are in line with the provider's risk assessment matrix.
• The risk assessment in relation to a resident being unsteady on their feet has been reviewed and updated to reflect all the control measures in place for the resident.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All medications are prescribed by a GP in line with residents' medical needs. This is the first safeguard to ensure safe administration of medication. The GP is knowledgeable of the medications individuals take and their potential interactions and contraindications.
• All medications are dispensed by a pharmacist as instructed by the GP's prescription. The pharmacist is the second safeguard in the process, when dispensing. They can highlight concerns to the GP regarding prescription safety where this arises.
• The pharmacist issues instructions at the time of dispensing advising of the safe administration of medication, including how to take the medication (before or after food, foods/ drinks to avoid). A patient information leaflet is also provided for each medication.
• Responsible and safe administration of medications (RSAMS) training is provided by the BOCSIL to all staff working in Community Services on commencement of employment to ensure the safety of all residents in relation to the safe administration of all medications, in line with organisation policies and best practice. This training includes three components, theoretical component, knowledge assessment and a number of competency assessments.
• The importance of following the guidelines issued by the pharmacy for all prescribed medicines is included in the medication training provided to staff. Individual medication

are not covered during this training.
• Medication Audits are completed on quarterly basis by Area Manager or delegate in line with the BOCSILR medication policy. The scope of medication audits covers storage facilities, medication packaging, drug prescription and medication recording charts and medication delivery audit.
• The responsibility of staff, as set out in the Policy for the Administration and Management of Medication of the BOCSILR, is to follow the guidance set out in the kardex as prescribed by the GP and to observe and follow the administration instruction as per the pharmacy dispensing label and Patient information Leaflet. The staff of the service are to adhere to the Policy for the Administration and Management of Medication Process within BOCSI-LR in all aspects of medication management.
• The six month unannounced process reviews AIRS and medication errors as part of this oversight. The reviewers rely on the quarterly medication audits of the Area Manager to provide more detailed oversight.
• As a result of the findings from the inspector, the provider submitted a provider assurance report to the Chief Inspector. The findings as set out in the Provider Assurance Report will be shared in by the Head of QET to determine in consultation with Head of Community and Director of Services if further oversight is required.
• The Pharmacist has advised that they will issue a Patient Information Leaflet for each person supported on medication dispensed on the next rotation.
• A review of RSAMS training by the RSAMS trainers will take place to reinforce the importance of reading and being informed by the information contained in the Patient Information Leaflets, to all attendees during the initial training and refresher training. These guidance is included in existing training materials.
• The BOCSIRL Policy on the Management and Administration of Medication has been referred to the BOCSILR Policy review group in the context of the performance assurance report to determine if the policy requires a review. This will include a review of the audit template to ensure it covers this aspect of the policy. This will also include review of administration of medication prescribed intermittently.
• Administration of medication will be put on the agenda of staff meetings whereby staff will be reminded of their responsibility in the administration of medication include the importance of following patient information leaflet guidance.
• The BOCSILR is exploring the possibility of a pharmacist carrying out ad-hoc medication audits.
• All dispensing pharmacies for the BOCSILR will be contacted to provide assurance to the service that all administration guidelines relating to prescribed medications will be detailed on all pharmacy dispensed packaging.
• Director of Services, Head of Quality and Head of Community to review six month unannounced review template in the context of this finding.
• The learning from this finding will be on the agenda for the next Person in Charge/Director of Services meeting on the 27th of August 2025.
• As a result of the findings by the Inspector the Person in Charge made an appointment with the GP of the person supported on 27th July 2025 in order to ascertain if this had had an adverse impact on the person supported. The GP advised that taking the medication the way it was administered would not have had an adverse impact on the resident. The GP's opinion is that the medication would still be effective.
• The GP recommended that going forward the prescribed medication should not be in the blister pack and should not be administered with a contradicting medication. It should be taken an hour before eating and before taking other medications.

• A protocol for the administration of the medication was written up and put on resident's medication folder. Resident is happy with the protocol.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• As a result of the findings by the Inspector the Person in Charge made an appointment with the GP of the person supported on 27th July 2025 in order to ascertain if this had had an adverse impact on the person supported. The GP advised that taking the medication the way it was administered would not have had an adverse impact on the resident. The GP's opinion is that the medication would still be effective.
• The GP recommended that going forward the prescribed medication should not be in the blister pack and should not be administered with a contradicting medication. It should be taken an hour before eating and before taking other medications.
• A protocol for the administration of the medication was written up and put on resident's medication folder. Resident is happy with the protocol.
• At the time of the inspection the resident had been referred for a dexa scan. At the GP appointment on 27th of July 2025 the GP sent a follow up letter for a dexa referral to the hospital.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The BOCSILR Policy on the Handling of the Personal Assets of Adults Supported by the Services includes a permission form which supports people to opt in or opt out of support from the BOCSILR in the management of their personal assets.
• No resident is restricted from managing their own personal assets if they choose to opt out of support from the BOCSILR. Residents may choose to manage their personal assets independently, with a decision supporter or another person outside of the services should they choose to.
• In order to support people to make an informed decision information is provided to them regarding the nature of the support that the BOCSILR can offer to them in terms of the management of their personal assets.
• At present the BOCSILR have identified one suitable deposit account and one suitable current account through which support can be offered in a safe manner both for the person supported and for staff.
• The BOCSILR Policy on the Handling of the Personal Assets of Adults Supported by the Services clearly sets out the limitations on direct access to personal assets inherent in the use of this type of account in order to ensure full transparency when a person is

choosing to opt in or opt out of support.
• Every effort is made to mitigate the impact of the restrictions on direct access to personal assets inherent in the use of this type of account and these are set out in the policy.
• Limitations on direct access to personal assets inherent in the use of this type of account as well as those in place to minimize the vulnerability to misappropriation of funds are not notified to the regulator as restrictions as each person support has the right to opt in or opt out of support.
• The BOCSILR is committed to exploring all alternative accounts that may facilitate less restrictive direct access to personal assets for people supported who opt in to support from the BOCSILR. In this regard the engagement with the assisted decision making department with the HSE seeking guidance in assisting residents in relation to banking arrangements was commenced on 11/11/2024. Engagement with banking institutions has also been perused to identify possible suitable banking products that would be a less restrictive alternative for residents within the service.
• As the actions of Bank institutions in response to this demand for type of bank account are outside of the control of the BOCSILR the date for compliance has been reflected as the 31st December 2026 to reflect this reality.
• Appendix 11 from the BOCILR Policy on the Handling of the Personal Assets of the Adults Supported by the Services relates to supporting holidays for people supported.
• Every effort is made to facilitate a holiday for residents. However this is limited to the roster of staff attached to each service location as there is no specific budget outside of the normal roster to provide holidays to residents.
• Where a resident has identified in their person centred plan that they wish to go on a specific holiday this is identified as a goal for the individual. From time to time this goal can be achieved through planning and consultation. The holiday may be facilitated within the existing roster or through an element of volunteerism by staff or a family member.
• The ability to plan for a holiday is also limited to the extent of the individual assets of the person support.
• This matter has been raised by the National Advocacy Council with the National Leadership Team of the BOCSI. As a result national guidelines are being developed in relation to social outings and holidays. This initial draft has been developed during 2025 and shared with the National Advocacy Council and is awaiting feedback. Once feedback is given the updated draft guidelines will be shared with each region and for agreement by the NLT.
• One resident goes on holidays every year with their family members.
• Two residents will be going on an overnight trip to a tourist town in August.
• The resident who had identified a named artist they would like to see in concert will be supported to do so in December 2025. Tickets for the concert became available recently the resident was supported to purchase them.
• The BOCSI-LR policy on the handling of personal assets of Adults Supported by the Services will be reviewed with a view to removing the use of the words ‘pocket money’ when referring to the personal assets of a person supported.
• The residents whose bedrooms are at the rear of the property have been consulted about other residents or staff accessing the patio areas via their bedrooms. They have provided written consent for access.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2025
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	31/12/2025
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	Substantially Compliant	Yellow	31/07/2025

	responding to emergencies.			
Regulation 29(2)	The person in charge shall facilitate a pharmacist made available under paragraph (1) in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland. The person in charge shall provide appropriate support for the resident if required, in his/her dealings with the pharmacist.	Substantially Compliant	Yellow	31/12/2025
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/12/2025
Regulation 06(2)(b)	The person in charge shall	Substantially Compliant	Yellow	27/07/2025

	ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.			
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Substantially Compliant	Yellow	31/12/2026
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	31/12/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships,	Substantially Compliant	Yellow	30/07/2025

	intimate and personal care, professional consultations and personal information.			