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:	Woodview
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	26 June 2025
Centre ID:	OSV-0008873
Fieldwork ID:	MON-0045285

About the designated centre

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

This designated centre is comprised of two bungalows located approximately 20 minutes apart. One house is located in the middle of a small town and supports one resident. The second house is located in a rural area close to a small town and can support up to three residents. The service offers full time residential supports for up to four adults with a primary diagnosis of intellectual disability. The larger bungalow provides each resident with individual bedrooms, two accessible shower rooms/bathrooms, open plan kitchen-dining room, living room, utility room, toilet, staff office. The bungalow supporting one resident contains a bedroom and accessible toilet, kitchen, dining room, living room, kitchen and utility room, relaxation room and staff office. Both properties have parking to the front and garden space to the rear. The residents are supported with a social model of care and the staff team is comprised of nurses and care assistants. Staff are available to residents both by day and night in both of the houses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 26 June 2025	10:30hrs to 17:20hrs	Elaine McKeown	Lead

What residents told us and what inspectors observed

The inspector completed a short announced inspection of this newly registered designated centre to meet with residents who had moved into one of the houses in November 2024. The inspection also focused on the provider's compliance with the regulations and to inform the decision in relation to progressing an application to vary the conditions of registration of this designated centre. The provider had submitted a complete application to register this designated centre in October 2024 which comprised of two houses. One house which supported one resident was already registered as part of another designated centre and process was followed to change to this designated centre. The second house had been subject to extensive renovations and three residents had been relocated to another designated centre while the upgrade works were being completed.

The provider had also submitted an application to vary the conditions of the registration of this designated centre in June 2025. The provider was seeking to add another property to this designated centre. This property had been re-designed and was being proposed to support two residents to live in self-contained apartments style dwellings.

This was the first inspection of this designated centre. At the start of the inspection, the inspector met with the person in charge and a person participating in management in the newly renovated property that had been identified in the application to vary the conditions of registration. The bungalow had been designed to create two self contained apartments that were linked by a corridor in the middle of the house. The property was found to be in a good state of repair with evidence of upgrade and re-design works being completed. This included the installation of fire doors throughout the property, wide hallways, multiple entry/exit points. Each apartment had a large bedroom which had ample space for furniture and personal belongings. Both apartments had a kitchen-dining area and living room as well as large accessible bathrooms. There was a staff office and bathroom in the central area of the building which was connected to both apartments. There was a large amount of outdoor space all around the property which was located next door to one of the other houses already part of this designated centre.

The inspector was informed the provider planned to offer the opportunity for two residents currently living in a campus setting to move into this property. This was part of the provider's overall de-congregation plan for a campus under the provider's remit. Transition plans and consultations had not yet begun with the proposed new residents as short time lines were important for both residents. However, the inspector was informed consultation regarding decor, furniture and paint colours would be fully inclusive of any resident who chose to move into this property. During the walk around of the property the inspector was informed of some works that remained outstanding relating to two fire doors, both doors required seals to be

installed on the bottom of each door. These parts had been ordered on 5 June 2025 and were scheduled to be installed once obtained by the external contractor.

The inspector was also aware prior to this inspection that an additional exit door had been installed into the office of the adjacent bungalow that was currently supporting one resident. The inspector visited this house briefly while the resident was not present and observed the door to be in place and functioning as it should. The resident had a schedule of activities planned for the day of the inspection which included visiting a relative in the afternoon. During the morning the resident had been supported to have their breakfast in a social venue and had requested to go for a drive so the inspector did not get to meet this resident during the inspection.

In the afternoon, the inspector met with three residents who had moved back into their renovated home in November 2024. There were two staff supporting the residents and all were introduced by the person in charge to the inspector. Two of the residents were in the living room, which had been darkened at that time and had soft lights and music playing. This appeared to be a relaxing space for the two residents who each had their own seating area. Staff explained that one of the residents was requesting to go for a drive and this was observed to be facilitated by one of the staff team a short while later. The third resident was initially resting in their bedroom when the inspector arrived.

The staff supporting the residents explained how the renovations to the house had improved the lived experience for the residents. This included the removal of a wall to create a larger kitchen-dining space for the residents. Staff outlined how one resident in particular liked to be able to see staff as meal preparation was taking place and this new layout assisted with this. The colour and decor created a warm, homely and welcoming atmosphere. Staff spoken too outlined a variety of activities that were regularly available for the residents to engage in if they wished. This included pet and music therapy in the house, visiting family in the locality and engaging in social activities in a nearby village and a larger town within a short drive.

Staff had commenced keeping a scrap book of photographs of activities for the year for each resident. These were seen to include visits to pet shops, public houses, scenic locations such as beeches and other events such as milestone birthdays where residents were seen to be smiling and enjoying themselves. Staff outlined how progress was being made with individual personal goals and these were documented as progressing in each resident's personal plan. For example, one resident had attained goals such as planting shrubs, attending music events and was about to commence planning an over night stay in a hotel. It was clearly documented for each resident if they were engaging in an activity routinely this was no longer to be considered a goal. This included if a resident was maintaining contact with family members. It was evident the staff team were striving to provide meaningful activities to each resident while considering their assessed needs and aging profile.

All staff demonstrated awareness of their roles and responsibilities. They spoke of how they supported each resident to make choices and decisions. The flexibility of

the staff team was evident to ensure a good quality service and meaningful activities were being provided for each resident. This included supporting individual and group activities in line with residents preferences. For example, while one resident liked to have a rest in the afternoon, one or both of the other residents could be supported to go out for a drive if they wished to do so.

The inspector was informed due to changes in the assessed needs of one resident living on their own in one of the properties, unfunded staff resources had been put in place by the provider since the start of June 2025 to support the well being of both the resident and staff team. While the resident was experiencing periods of increased anxiety, it was evident from documentation reviewed by the inspector that the staff team were continuing to support the resident to engage with social activities that they enjoyed once they had self- soothed themselves. Ongoing input from the multi-disciplinary team and consultants clearly documented the review taking place which included medication reviews, a review of supports being provided and the location of these supports within the house. In addition, the inspector was informed that the provider had submitted a business case to the funder to seek additional funding for the resources currently required to support the resident in their home which had been working well for the resident since they moved in during June 2023.

During the walk around of the third property in the afternoon, it was noted that while the atmosphere was homely the inspector discussed the rationale for having personal protective equipment such as aprons and gloves located in a prominent location in the kitchen-dining area. Staff explained the use of such equipment to support the assessed needs of the residents but considered alternative options to maintain a home like environment. The inspector noted that these items had been removed before the end of the inspection. In addition, staff had not considered the possible impact for residents right to privacy and dignity regarding two other situations identified by the inspector during the inspection. The inspector observed information pertaining to the residents assessed eating needs were written and stuck on the outside of a kitchen press with each of the residents initials. The use of incontinence wear to protect seating used by a resident was also discussed during the feedback at the end of the inspection. This will be further discussed in the quality and safety section of this report.

In summary, it was evident the three residents had settled back into their home in November 2024 after upgrade works had been completed by the provider. A core consistent staff group were supporting the residents to engage in meaningful activities. Staff were observed to provide person centred care and support to the residents during the inspection. However, further improvements were required to ensure there was a consistent approach to maintaining each resident's privacy and dignity in their home. Regarding the second property, the provider had taken actions, including providing unfunded staff resources to ensure one resident was being effectively and safely supported during a period of a change in the resident's presentation and behaviours in recent weeks. In addition, the provider had ensured the third property which it was seeking to add to this designated centre had been

completed to a high standard and was part of the provider's overall de-congregation plan for a large campus under their remit.

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 good quality care and support. This resulted in good outcomes for residents in relation to the wishes they were expressing regarding how they wanted to spend their time in the designated centre. There was evidence of strong oversight and monitoring in management systems that were effective.

The provider had effective systems through which staff were recruited and trained, to ensure they were aware of and competent to carry out 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, one resident was informed they would be able to go out for a drive in a short while when they approached the front door. The staff member went with the resident to the living room and sat down next to the resident for a few minutes until the other staff was ready to bring the resident for a drive.

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. A provider led six monthly audit was completed on 27 January 2025, all actions had been progressed and completed with updates documented by the person in charge. Additional audits during 2025 included medication and infection prevention and control audits. Many of these audits had evidence of good practices and no actions identified. Where an action had been identified these were addressed and completed in a timely manner.

Registration Regulation 8 (1)

Prior to this inspection taking place, the provider submitted a complete application to vary condition 1 and condition 3 of the current registration of this designated centre. The provider had requested an additional property be added to the designated centre. The proposed property was visited during this inspection and found to be suitable to support the provision of residential services for an additional two residents in line with the application to vary that had been submitted to the Chief Inspector. An issue relating to two fire doors on the property that were awaiting the installation of additional doors seals will be actioned under Regulation 28 :Fire precautions.

In addition, an exit door to the rear of the property was added to an office in one of the existing houses in the designated centre to provide an additional exit point for staff working in the house. This was viewed by the inspector during this inspection and found to be reflective of the information and floor plans submitted as part of the application to vary the conditions of registration of this designated centre.

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, management and allied healthcare professionals. Their remit was over this designated centre. They were available to the staff team by phone when not present in the designated centre.

The person in charge had systems in place to ensure regular meetings each week with residents and the staff supporting them were taking place. The person in charge had also completed audits within the designated centre since November 2024 which included medication audits, infection prevention and control and financial audits.

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 was comprised of nurses and healthcare staff.
- There were no staff vacancies at the time of the inspection.
- The provider had ensured additional unfunded staffing resources were being provided to a resident living alone in one of the houses who required increased supports due to a change in their assessed needs. This unfunded support was in place since 7 June 2025 to ensure the well being and safety of the resident as well as supporting the staff team.
- The provider had ensured staffing resources from another designated centre located nearby were available when required both by day and night to support the staff team in one of the houses in this designated centre.
- A selection of dates were reviewed on both actual and planned rosters since from 20 April 2025 to 26 July 2025, 14 weeks. These reflected changes made due to unplanned events/leave. 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. The commencement of day time shifts were staggered to support the assessed needs of the residents.
- At the time of this inspection, there were separate rotas pertaining to the day shifts, night shifts and the management oversight in the designated centre. These were made available to the inspector during the inspection.
- However, the documenting of the additional unfunded staff resources since 7 June 2025 was noted to be inconsistent on the actual rotas. The inspector was informed the staff hours were being recorded in the designated centre where the staff member routinely worked. Some of these staff worked in this designated centre while others worked in another designated centre located nearby. While the process of recording these resources was explained to the inspector, the actual staff rota for the designated centre did not accurately reflect the staff on duty on a number of dates in recent weeks, for example on the day of the inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

At the time of this inspection the staff team was comprised of 15 members which included the person in charge, five nurses, two social care staff and seven care staff. In addition, the inspector was informed a total of 17 other staff had provided support to the staff team in recent months.

- The person in charge had completed a schedule of staff supervisions during 2024 in line with the provider's policy, once per quarter. If a staff had been

relocated, commenced employment or was on leave this was reflected in the records provided.

- A schedule of supervisions for 2025 had been commenced by the person in charge, with 15 staff having had supervisions during quarter 1 2025. This included staff on night duty and probationary appraisals in line with the provider's protocols. Planned dates for quarter 2 and 3 2025 supervisions were also documented.
- The person in charge met with all members of the staff team both day and night staff regularly.
- The person in charge was present in both of the current houses in the designated centre each week and ensured all staff were appropriately supported and supervised.
- All staff working in the designated 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, safety intervention, safeguarding of vulnerable adults and manual handling. The person in charge also provided the training records for the 17 staff that had provided additional support in recent months. All these staff had all their training up-to-date.
- The person in charge had an effective system in place to ensure refresher training was planned and booked in advance for those team members that required training during 2025. The person in charge was aware at least three months in advance of when refresher training might be required by a team member so they could arrange/ schedule the training. This system aided the inspector's review of the training matrix that was provided during the inspection.

Judgment: Compliant

Regulation 19: Directory of residents

The provider had ensured a directory of residents had been established and maintained in the designated centre. The details included all of the required information specified in paragraph (3) of Schedule 3.

Judgment: Compliant

Regulation 23: Governance and management

The provider was found to have suitable governance and management systems in place to oversee and monitor the quality and safety of the care of residents in the centre. 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. When additional staff resources were deemed to be required to support one resident due to a change in their assessed needs, the unfunded staff resources were being provided since the 7 June 2025 and remained in place on the day of the inspection.

An audit schedule for 2025 was in place for the designated centre. Audits since January 2025 were completed in line with the schedule, with good findings reported in the audits completed to date. Any issues identified were progressed, addressed and completed within a short time frame. For example, some actions were documented as being addressed on the day the audit took place such as replacing damaged folders that were being used to hold residents medication charts.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was subject to regular review. The most recent review in May 2025 reflected the changes proposed to increase the number of houses registered to this designated centre and the total number of residents being supported. It reflected the services and facilities provided at the centre and contained all the information required under Schedule 1 of the Regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had ensured a complaint policy was in place and subject to review by the provider. Details of who the complaint officer was were observed to be available within the designated centre.

Staff were found to be knowledgeable about the process of how to make a complaint and it was evident in meeting notes that residents were informed during residents meetings about the complaint process.

No complaints had been made in either of the current two houses since residents moved into their homes in June 2023 and November 2024 respectively.

A number of positive comments from family representatives had been recorded in a number of documents that were reviewed during the inspection.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the quality and safety of care provided for residents was of a good standard. Residents were being encouraged to build their confidence and independence, and to explore different activities and experiences in the community. Residents were also supported to maintain links with family and friends.

The three residents in one house were observed to be content in their home during the inspection and supported by a staff team that were familiar to them. The re-design of the building had improved the experiences for the residents relating to meal preparation and engaging more with the staff team.

There was ongoing input and supports being provided to one resident who was experiencing a change to their assessed needs in recent months. The staff team had voiced concerns to the person in charge regarding the difficulties being experienced when supporting the resident with activities of daily living such as showering, brushing their teeth and shaving as well as other intimate care needs. These activities had been identified as possible triggers to causing increased tension and anxiety for the resident. However, it was evident the staff continued to support the resident to engage in meaningful activities once the resident had self regulated themselves.

A review had taken place with the staff team to enhance safety measures and make changes to routines and locations in the house where personal care activities were supported to try to alleviate the tension being experienced by the resident. There was an ongoing trial regarding the use of equipment following a review by an occupational therapist. The resident had also been supported to commence antibiotic treatment on 13 June 2025 to manage a medical condition that had been identified following a blood test.

The resident had an up-to-date behaviour support plan in place which was person centred and detailed how focussed supports were not currently effective for the resident. The guidance for the staff team included calming distractions, re-direction and how to engage with the resident during such periods of escalation.

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 and visual signage were available for a range of topics including safeguarding, advocacy and consent.

Residents also had access to telephone, television and Internet services.

Each resident had a communication passport in place which were reflective of individual assessed needs. For example, one resident who had hearing and visual impairments was being supported by staff in line with recommendations made by a speech and language therapist in November 2024. This included staff being aware to give the resident time to explore their environment, using a personal communication dictionary and objects of reference.

Judgment: Compliant

Regulation 11: Visits

The registered provider had ensured residents were supported to receive visitors in their home. Family members were welcomed at times that best suited residents.

In addition, residents were supported to visit relatives regularly. This included pre-planned visits every two weeks to the family home of one resident. During the inspection staff also informed the inspector of a positive outcome for another resident who had recently called to the home of a family member unannounced. The resident and staff were in the locality and were welcomed into the home by the relative who was reported to be very happy with the surprise visit.

Judgment: Compliant

Regulation 12: Personal possessions

The person in charge had ensured each resident had access and retained control of their personal possessions. Residents had adequate space to store their possessions in their bedrooms. It was noted that one resident's shoes were on the floor in an orderly fashion in their bedroom. Staff explained a shelving unit was planned to be purchased with the resident where they may chose to place their shoes.

While some residents may chose not to assist with laundering their own clothes, access to the laundry facilities was available to residents if they chose to participate.

All residents had their own bank accounts, bank cards and had access to their finances. Staff provided support where required and regular financial audits were

completed by the person in charge to ensure transactions and receipts were consistently documented in line with the provider's processes.

Judgment: Compliant

Regulation 13: General welfare and development

The provider had ensured each resident was being supported with appropriate care and support. While the current residents did not attend a regular day service they were supported to access community services, social farms and engage in activities in line with expressed wishes and preferences.

Residents were supported to regularly engage in activities to enhance and further develop skills such as sensory baking and gardening.

Residents were supported by familiar staff to engage in meaningful activities, with flexibility evident when non- timetable activities were taking place. For example, when one resident was experiencing difficulties staff allowed the resident time to self regulate themselves in line with their positive behaviour support plan and the resident was then offered opportunities to make choices of what they would like to do.

Judgment: Compliant

Regulation 17: Premises

Overall, the designated centre was found to be clean, well ventilated and comfortable. Communal areas were large and spacious.

- All three properties had been designed to meet the assessed needs of the current residents and could support residents in the future if increased use of mobility aids were required. This included wide hallways, accessible bathroom areas and large bedrooms.
- Upgrade works including painting and decor were completed to a high standard with input from the residents in the current two houses.
- To better support the assessed needs of one resident a room in their house was being re-designed to create a setting to enhance the quality of life for the resident. This upgrade was an outcome of an occupational therapy assessment completed in June 2024. The inspector was informed sensory equipment had been ordered and was expected to be in place within weeks after this inspection.
- The newly upgraded property being proposed by the provider to become part of this designated centre was found to be ready to support residents with all

structural works completed. Further works including additional painting and personal choices of the residents who will be supported to move into the property will be part of these residents transition plans once commenced.
- The provider had added an additional exit door from the office in one of the current houses. This was noted to be in place and reflected in the most recent floor plans of the designated centre.
- There was evidence of ongoing review and reporting of all maintenance issues which included cracked tiles on the floor in one of the bathrooms in the house supporting three residents.
- To ensure improved accessibility for staff using a mobility aid to support a resident getting into and out of bed a new bed which would better aid access of the mobility aid under the bed had been ordered.
- In addition, the provider had ordered generators to be installed for use in all three properties as a result of the loss of power during the extreme artic weather in January 2025. This would reduce the risk of residents being without power in the future if a similar situation occurred.

Judgment: Compliant

Regulation 20: Information for residents

The registered provided had ensured a residents guide had been prepared in a format that suited the communication needs of the current residents and was available to all residents in the designated centre.

In addition, easy -to-read guides pertaining to topics such as fire evacuation, safeguarding and advocacy were also available and used to discuss issues with residents during residents meetings.

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 were no escalated risks at the time of this inspection.

Centre specific risks had been reviewed by the person in charge in December 2024 and as required since that date. There were measures in place to ensure the safety of residents and staff in the designated centre. This included the staff skill mix in the event of a nurse not being available to work in the designated centre. This had occurred once since the centre was registered. It occurred on 15 December 2024,

control measures included support from on-call management in the provider's campus and the control measures in place were deemed to have been effective.

Individual risk assessments had also been completed and subject to regular review by the staff team. Measures were in place to ensure the safety and well being for residents. For example, one resident who was visually impaired required staff support to ensure their shoes were correctly fastened to avoid risk of injury from falling. Another resident had an unsteady gait and needed staff support to avoid hazards in their environment. The additional staff resources being provided to one resident in recent weeks was also part of a risk assessment to ensure the safety of the resident and the staff supporting them. This risk had been subject to ongoing review and updated as required.

In addition, the use of a double walled kettle in one of the houses resulted in no restriction for one resident to access the kitchen area and measures were in place to avoid a risk of injury to the resident which staff explained to the inspector during the inspection.

Judgment: 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 in both of the current houses in this designated centre.

- The person in charge had ensured the staff team completed regular fire drills including a minimal staffing fire drill, in both of the houses. For example, in one of the houses such a drill was completed on 20 Feburary 2025. The staff member supported the three residents to exit the building via two different exits and outlined the support needed to be provided to one of the residents who initially was reluctant to evacuate. The inspector sought clarification regarding the fire evacuation plan of this house as two of the residents required the use of a wheelchair with a minimal staffing level of one staff on duty at night time. This was provided during the feedback meeting at the end of the inspection. All fire drills documented the exits used and a senario to ensure staff were using the closest exit and not crossing the location of a potential fire.
- All staff had completed training in fire safety and two of the staff team were trained as fire marshalls.
- 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.

- To encourage one resident to participate in fire drills staff referred to information videos shown to the resident as part of encouragement activities as the resident's "fire safety class"
- The provider had ensured all exits were suitable for wheelchairs to use to support the assessed needs of residents. All exits were viewed as being free from obstruction during the inspection.
- The provider had submitted certification relating to fire safety pertaining to the newly upgraded property that was being proposed to become part of this designated centre as part of the current application to vary. The inspector was informed a review of the property by a person competent in fire safety took place on 5 June 2025. An issue relating to fire seals on the base of two doors was identified and the required parts were ordered. The inspector was shown both of the doors during the walk around of the property. The inspector advised during the feedback meeting that assurance would be required to be submitted to the Chief Inspector that the issues identified in the recent fire safety inspection had been addressed.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had ensured that the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medications.

Medications were administered by the nurse on duty both by day and night. An additional member of the staff team had completed training in the safe administration of medications.

Ongoing review of practices and medication audits in the designated centre had identified no actions to be taken since January 2025. There had been two medication errors documented, one of these was as a result of prescribed medications not being able to be administered to a resident due to them experiencing heightened anxiety at the time and this was documented in line with the provider's policy on the safe administration of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed one resident's personal plan and different sections of personal plans for two other residents during the inspection. There was evidence of

ongoing review by key workers and the person in charge. This included staff being advised to archive documents in line with the provider's policy.

It was evident staff were working in conjunction with residents and their family representatives in the annual review of personal plans. For example, the review of one resident's personal plan was scheduled for a date that suited a family representative who wished to be present.

Residents goals had been subject to review and where previous goals were now regular activities these were no longer considered a goal for the resident and new goals had been developed. For example, a resident regularly visited Knock which had been a previous goal. Staff were exploring options to progress newly identified goals such as visiting an airport and going on a boat trip. Updates on the progress of these goals included three successful and positive experiences at the airport for the resident in June 2025.

One resident who was experiencing difficulties in recent months had been subject to ongoing input and review from members of the multi-disciplinary team. Since Feburary 2025 the resident had presented with difficulties and increased distress relating to particular activities of daily living. Input from allied health care professionals such as behavioural support specialists, occupational therapist and psychiatrist was evident to be taking place with supports being put in place to assist with alleviating the tension being experienced by the resident.

Referrals to allied health care professionals for other residents had also been made and assessments completed as required. This included a review in November 2024 by a speech and language therapist for one resident where the importance of offering choice to the resident was part of the recommendations made. Staff were observed to be aware of this when talking to the inspector.

Judgment: Compliant

Regulation 6: Health care

The person in charge had ensured all residents were being supported to have their health care needs met by appropriate health care professionals, this included general practitioners and consultants.

Residents were being supported by a staff team that provided nursing supports by day and night.

Residents were being supported to attend for regular medical appointments and health checks. A further update was required relating to one resident where it had been documented there was a family history of an illness and while the required screening had been completed previously, on the day of the inspection it was unclear if the most recent screening had been documented in the resident's health

management plan. The person in charge was reviewing this on the day of the inspection.

One resident was being supported on the day of the inspection by the staff team with ongoing monitoring as the resident had developed a temperature on the morning of the inspection. The inspector was informed of the supports being provided and the plan to seek a review with the resident's general practitioner if there was no improvement in their presentation.

Judgment: Compliant

Regulation 7: Positive behavioural support

The three residents who lived in one of the houses were reported as getting on well together with good interactions and routines suiting the group. Staff were aware of preferred communication methods and seating arrangements, in particular in the living room and dining room and as staff were familiar with these preferences the atmosphere within the house was described as friendly and working well for the residents.

Specific support plans were in place for one resident who was experiencing increased tension in recent months who lived in another house on their own with staff support. There were protocols to ensure the safety of the resident and the staff team which included personal alarms being available and functioning when staff were providing support to the resident. Staffing resources to suit the daily routine were subject to review to ensure the most effective supports were in place when required by the resident.

Input from the provider's clinical nurse specialist in behaviour support was requested in February 2025 to identify if any possible physical issues were the root cause of the changes being displayed by the resident.

Sensory equipment that had been recommended by an occupational therapist following an assessment to provide additional supports to the resident in their home had been confirmed on 5 June 2025 by the supplier as been ordered and were expected to be installed in the weeks following this inspection.

The person in charge ensured all staff had read and signed this resident's positive behavioural support plan, including new staff and additional staff resources that were being provided by the provider. This plan ahd been subject to recent review and provided guidance for staff to effectively support the resident.

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.

There were no open safeguarding plans at the time of this inspection.

Personal and intimate care plans were clearly laid out and written in a way which promoted residents' rights to privacy and bodily integrity during these care routines.

There was ongoing review to support the recently changed presentation of one resident relating to their intimate care needs. Alternative measures were being trialled to assist in reducing the anxiety being experienced by the resident while staff were providing support during personal care. Input from the occupational therapist had been sought on 3 April 2025 to assist the staff team with finding a solution while promoting the residents privacy and dignity. The person in charge had completed a risk assessment and escalated the referral in line with the provider's procedures to request the provider's occupational therapist to complete the assessment as a community occupational therapist was not available.

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.

- Staff ensured residents were being provided with a person centred service in a relaxed environment.
- Residents expressed wishes and preferences to spend time in the designated centre was respected.
- Staff were encouraging residents to part take in community activities, such as visiting social farms and accessing local services.
- Residents were supported to manage their personal finances.
- The provider was undertaking a review of the advocacy structure that was in place within the organisation and this would be part of the services being offered to residents in this designated centre.

However, further review was required to ensure each residents dignity and privacy was consistently maintained.

- The use of incontinence wear to protect seating in a communal area did not ensure the dignity of the resident was being supported while in this location.

- Residents personal information regarding their assessed needs relating to eating was visible on the outside of a kitchen press. This was a communal area where visitors to the designated centre would be able to view this information.
- In addition, the inspector observed the use of terms in communication notes and in fire drill records where the residents were referred to using terminology that would not be associated with adults, but could be considered as affectionate terms. The person in charge outlined that this issue had been previously identified and had sought to provide additional supports to ensure staff were aware of the requirements relating to the use of respectful documentation regarding 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	
Registration Regulation 8 (1)	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Woodview OSV-0008873

Inspection ID: MON-0045285

Date of inspection: 26/06/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Person in Charge has reviewed the current roster and it now reflects the actual the staffing day & night and the additional unfunded staff resources in the designated centre. • Business case, which was submitted to the HSE will continue to be progressed for the unfunded staff resource to support one individual.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The seals on the two fire doors that were ordered prior to the Inspection were installed on the 17th July.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Following the inspection the Person in Charge met with the staff to discuss the use of incontinence sheet to protect seating in a communal area. The incontinence sheet was removed ensuring the dignity of the resident. • Following the Inpection the Person in Charge met the staff team and discussed the use of resident personal information being on display. This information was removed and is	

readily available in a folder in the designated centre.
• Following the Inspection the Person in Charge met with the staff team and discussed the use of terms in communication notes and appropiate use of language.
• All staff have completed their Code of pratice training. The Person in Charge who is a Code of Practice Trainer will provide additional supports around the use of language.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	04/07/2025
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Substantially Compliant	Yellow	17/07/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not	Substantially Compliant	Yellow	25/07/2025

	limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			