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:	Liscarra
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	03 October 2022
Centre ID:	OSV-0007862
Fieldwork ID:	MON-0036768

About the designated centre

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

Liscarra consists of four bungalow type residences and a larger one-storey building located on a campus setting on the outskirts of a city. Two of the bungalows can provide full-time residential care for five residents each. The other two bungalows can support full-time residential care for three and four residents respectively with each of these bungalows subdivided into two apartments. The other building in intended to serve primarily as a COVID-19 isolation unit and can support up to four residents. Overall the centre has a maximum capacity of 21 residents over the age of 18 of both genders with intellectual disabilities. Each resident living in the bungalows has their own bedroom and other facilities throughout the centre include bathrooms, day/dining areas and kitchens amongst others. Residents are supported by the person in charge, nursing staff and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 3 October 2022	10:00hrs to 19:30hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

The residents met during this inspection generally appeared calm and content. While some residents were supported to go out into the community, other residents did not appear to be engaging in meaningful activities. While efforts had been made to make the bungalows where residents lived homely, the bungalows visited during this inspection needed further maintenance, decoration and cleaning.

During this inspection three of the five buildings that made up this designated centre were visited. Two of these were bungalows where residents lived while a third was a large building that was primarily intended to serve as a COVID-19 isolation unit if required to support residents from this centre or other centres operated by the registered provider. When the inspector visited this unit no residents were present although the inspector was informed that it was being prepared to support a resident from another designated centre later on in the day. It was noted this unit was generally well maintained although the inspector did observe that some floors were marked while in one bedroom that had used temporarily by a former resident it was seen that a number of tape markings were on the wall. As the inspector was leaving this unit he observed that a bottle sanitiser present just inside the front door had expired in April 2022.

Hand sanitiser was also present in the two bungalows visited during this inspection. Both of these bungalows were of a similar size and layout. While efforts had been made to make these bungalows homelike, such as some recent painting that had been done in one bungalow, there were parts of both bungalows that were of a poor standard and in need of maintenance, decoration and cleaning. These included cracked tiles, rusted fixtures, chipped and worn kitchen surfaces, marked doorframes and doors, worn taps and sinks, a toilet seat that needed replacing, and an oven that required cleaning. Some parts of the bungalows were reasonably presented including the bathrooms in one bungalow while each resident living in these bungalows had their own individual bedrooms which were noted to be personalised and in general were reasonably furnished and maintained.

Three residents were living in each of the two bungalows visited by the inspector all of whom were met during this inspection. While some residents did acknowledge the inspector, interacted was limited with the inspector. As such the inspector used his time in the residents' home to observe residents in their home setting and in their interactions with each other and staff members present. During one period of observation in one bungalow, it was observed that some residents spent a noticeable period of time sitting in the bungalow's day room listening to a radio or watching a television. While residents appeared quiet and content at this time, the inspector did not hear or observe any interaction between residents nor between residents and staff present during this time although the inspector did overhear one resident interacting pleasantly with an external cleaner who visited the bungalow for a time.

In addition, three different delivery people arrived at this bungalow while the inspector was there. One entered the bungalow's kitchen without knocking or announcing their arrival. This person was not wearing a face mask but only stayed momentarily and did not meet any residents or staff. A second delivery person entered the bungalow without knocking but did announce themselves after entering while wearing a facemask. The third arrived at the bungalow's front door and waited for a member of staff before handing over their delivery and departing. In the other bungalow, no delivery people were seen and residents were also observed to sit in the day room while the television was on. At one point one resident went to one of the bungalow's bathrooms and was heard to call out a number of time while there. Staff responded promptly to each of the resident's calls while neither of the other two residents present appeared to react to this with things generally calm during the inspector's time there.

While the inspector was in one bungalow some residents living there were seen to go for walks independently around the campus where this centre based. They were also noted to freely come and go from the bungalow without the assistance of staff members. It was indicated that such walks were important for these residents. Walks were a regular activity that residents were indicated as doing according to records reviewed. When reviewing a sample of activity records it was seen that some residents were being supported to engage in activities away from the campus in the community such as going to have a pint in pub while some residents had recently attended a wildlife park. However, activity records reviewed for other residents indicated that they did not engage in meaningful activities nor interact with their local community. For example, when reviewing two residents' activity records for the weeks leading up to this inspection it was seen that their days consistently largely of walks, drives and watching television or listing to music.

In summary, aspects of the bungalows where resident lived needed improvement. Of the six residents met during this inspection, none of them indicated to the inspector their views on life in the centre but generally appeared calm and content. Some residents appeared to be availing of more meaningful community based activities then other residents.

The next two sections of the report 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 delivered

Capacity and capability

A restrictive condition was attached to this designated centre and the registered provider had not provided sufficient assurance that they could meet this condition. This remained an ongoing concern that had been evident through 2021 and 2022.

This designated centre was made up of one building which was intended to be

primarily used as a COVID-19 isolation unit and four bungalows which residents lived in on a full-time basis. All five were located on the same campus with the four bungalows where residents lived previously having being part of other designated centres on the same campus until a reconfiguration conducted by the provider during 2020. This reconfiguration was carried out by the provider to coincide with a plan to improve the fire safety systems across the overall campus. This plan outlined specific dates when fire safety upgrades were to be carried out for three of the bungalows of this centre. Following significant regulatory activity by the Health Information and Quality Authority (HIQA), registration of this centre was only granted in January 2021 with a restrictive condition which required the provider to implement this plan. This plan indicated that fire safety works for one bungalow were to commence in February 2022 and the three were to have works completed by February 2023 with the remaining bungalow to be closed by May 2023.

From engagement between HIQA and the provider throughout 2021 and 2022, it was evident that such time frames would not be met with resourcing of the overall plan a particular concern. During such engagement the provider had put forward some alternative plans for consideration but had been unable to provide sufficient assurance as to how such these plans would be fully resourced. Given that the regulations require registered providers ensure that designated centres are appropriately resourced, and taking into account extensive engagement between HIQA and provider concerning the campus, the provider was advised during a cautionary meeting with HIQA in May 2022 of the consequences of continued non-compliance with registration conditions and relevant regulations. HIQA also reiterated this in separate communication issued to the provider on the day of this inspection which was intended to monitor compliance with relevant regulations following two inspections of this centre in 2021.

This inspection found that fire safety works had not commenced on any of the three bungalow where fire safety works were to be done and there was no clear indication if they would commence. As such the overall resourcing of the centre remained an ongoing concern and contributed to noncompliances being identified in other regulations as discussed elsewhere in this report. The November 2021 inspection of this centre had also highlighted other resource limitations with some residents of this centre having not availed of assessments from particular health and social care professionals such as an occupational therapist (OT) and a speech and language therapist (SLT). While access to these professionals remained a risk for the entire campus, on the current inspection it was indicated that no residents of this centre were waiting on an assessment from an OT or an SLT. This was a positive development although it was indicated that psychiatry support for the campus had been recently impacted which could pose issues in the future.

The November 2021 inspection also highlighted that there were times during the day, including overnight, when some residents who lived in three different bungalows did not have staff available to support them in their homes on a 24-hour basis which the centre's then statement of purpose indicated that they had. Since then the provider had changed their statement of purpose to reflect the actual level of staff support provided to impacted residents during the day and night. At the time of this inspection it remained the case that at certain times some residents did not

have staff support in their homes. At such times the provider sought to mitigate any potential risks or negative impacts by having staff from some bungalows perform regular checks in the other bungalows where impacted residents lived. The provider was assessing this matter on a regular basis but it was noted the potential impacts for one resident who did not have staff in their home overnight had been assessed as a higher risk.

While this was a matter that required to be kept under close consideration, it was found on this inspection that the consistency of staff working in this centre had improved since the November 2021. In particular it was noted that lower amounts of different individual staff had worked in the centre during the day then was previously found although it was still found that the consistency of staff at night continued to require some improvement. Despite this though there was evidence on this inspection that staff working in this centre were being formally supervised. This was evidenced from a supervision schedule reviewed and a sample of individual staff supervision records where matters such as safeguarding and training were indicated as being discussed. Staff training records reviewed also indicated that all staff working in this centre had undergone relevant training in key areas to ensure that they could support residents.

Staffing was an area that was considered by the provider's monitoring systems in place which included annual reviews and unannounced visits to the centre by a representative of the provider. Both of these are required by the regulations with reports of an annual review and one provider unannounced visit completed since the November 2021 HIQA inspection available for the inspector to review on this inspection. It was read how the annual review focused on relevant standards and provided for consultation with residents and their families while the unannounced visit report contained an action plan for responding to issues identified. However, during the feedback meeting for this inspection it was indicated to the inspector by the centre's person in charge that a provider unannounced visit to the centre was to take place the day after this HIQA inspection with management of the centre having been informed in advance of this. While it was indicated that staff working in this centre were not aware of this impending visit, the provider would need to ensure that notifying the centre's local management of such a visit in advance did not compromise the intended nature of unannounced visits as is outlined in Regulation 23 Governance and management.

Regulation 15: Staffing

While staffing arrangements were being kept under review and the consistency of staff working in the centre had improved somewhat since the previous inspection, staffing continuity in the centre, particularly at night, continued to require improvement.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were being supervised and provided with relevant training in areas such as fire safety, safeguarding and infection prevention and control.

Judgment: Compliant

Regulation 23: Governance and management

Taking into account delays in progress with an overall fire safety plan, which impacted some of the bungalows of this designated centre, HIQA were not assured that this designated centre was appropriately resourced. This was an ongoing issue which had been the subject of extensive regulatory engagement between HIQA and the provider throughout 2021 and 2022.

Judgment: Not compliant

Regulation 3: Statement of purpose

The centre's statement of purpose contained all of the required information and had been recently updated.

Judgment: Compliant

Quality and safety

The four bungalows of this centre continued to have limited fire containment measures. While residents' health needs were being supported, the security of medicines storage required improvement.

As highlighted earlier in this report, some of aspects of the buildings visited during this inspection needed improvement. Such issues had been identified in previous HIQA inspections and were directly related to resourcing and some buildings being of a poor standard. However, changes in circumstances meant that there had been some premises related improvements. For example, an inspection in May 2021 raised concerns about the suitability of one bungalow to support a resident who used a wheelchair but this resident had since moved to another centre on the

campus with more space. The number of residents living in this bungalow had reduced at the time of the inspection but it was indicated that the provider was considering a new admission to this bungalow which, given the overall size and layout of the bungalow, would limit the availability of communal space there.

Space was an issue in the two bungalows visited during this inspection and in both of them it was seen that medicine presses were stored in the kitchen right beside a fridge. The inspector was informed that the provider was looking to create a staff office in each of these bungalows which could be used to store medicines in the future. While these medicine presses were seen to be locked, it was noted that the keys to both were left in a plastic container left on the respective kitchen worktops. This did not provide assurances that medicines were being stored securely particularly taking into account that a delivery person was seen to freely enter the kitchen of one of these bungalows. The inside of both of these medicines presses were reviewed by the inspector and found to be reasonably organised but, while most medicines reviewed were in date, the inspector did find that some contents in one press had been expired since 2019 and 2021.

A sample of medicines records were reviewed during this inspection. It was noted that these were well maintained and contained key information. The records also indicated that the majority of medicines for residents were being given as prescribed. The inspector did note though that for one resident some items were listed on the resident's list of regular prescribed medicines to be used twice a week but per the resident's administration records, they were not recorded as being used consistently in recent months. Other records related to residents' health were reviewed during this inspection which indicated that residents were supported to access certain health and social care professionals when required and to avail of relevant national screening services. Guidance on how to support residents with their assessed health needs was provided by specific health care plans which were noted to have been recently reviewed.

These health care plans were contained within residents' individual personal plans. Such plans are required by the regulations and are intended to set out the health, personal and social care needs of residents. A sample of personal plans were reviewed by the inspector and it was found that they contained various information on how to support residents' needs. Residents and their families were also supported to be involved in the review of these personal plans through a person-centred planning process where goals were identified for residents to achieve. There was evidence that such goals were being reviewed regularly and residents supported to achieve these. For example, residents had been supported to have overnight stays away from the centre. Residents' personal plans were also subject to multidisciplinary review as required by the regulations. These regulations also require personal plans to be available in an easy-to-read format but the inspector was informed this was not in place for the residents of this centre.

Aside from personal plans the inspector also reviewed documentation related to fire safety in the centre. As discussed earlier in this report, this centre had a restrictive condition in place related to fire safety with four of the five buildings which made up this centre having limited fire containment. This was a longstanding issue which

remained unchanged at the time of this inspection. Such buildings did have other fire safety systems in place which included fire extinguishers and fire alarms while fire drills were also being conducted on a regular basis with low evacuation times recorded from a sample of drill records reviewed by the inspector. However, when reading one such record the inspector noted that one resident had refused to evacuate on a recent fire drill. The resident did have a personal emergency evacuation plan (PEEP) which did outline a measure to take to support the resident to evacuate if they refused in a real fire scenario. This was queried with staff during the inspection with one outlining different methods to support the resident to evacuate then was listed in their PEEP while a second staff indicated that they would make sure the resident evacuated without describing how this would be done.

Staff members had undergone relevant fire safety training along with other relevant training in areas such as safeguarding. Since the previous HIQA inspections of this centre in 2021, some residents living in this centre had moved into different buildings within the centre and in other designated centres on the same campus. This helped to provide these residents with different living environments which were more suited to their needs while it also ensured that some safeguarding concerns previously evident in one bungalow had been addressed. This was a positive development and HIQA had not received any notification of a safeguarding incident having impacted the residents of the centre since the November 2021 inspection. Despite this, some staff in one bungalow indicated that one resident could have a negative impact on a peer they were living it. Management of the centre indicated that such concerns had not been raised with them previously. This was a matter that needed to be reviewed and risk assessed.

Regulation 13: General welfare and development

While there was some indications that some residents were availing of activities away from the campus where they lived, for other residents recorded reviewed indicated that the majority of activities they were partaking in were not meaningful and were primarily based on the campus where they lived.

Judgment: Not compliant

Regulation 17: Premises

Parts of the premises visited during this inspection remained of a poor standard and in need of maintenance, decoration and cleaning while the size and layout of one bungalow visited did not offer much communal space.

Judgment: Not compliant

Regulation 26: Risk management procedures

Taking into account comments made by some staff, the provider needed to review and risk assess if one resident was having an impact on another resident they were living with.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were gaps in some cleaning records reviewed although it was noted that cleaning was indicated as being done consistently in the weeks leading up to this inspection. A bottle of hand sanitiser seen in the COVID-19 isolation unit of this centre had expired. While the provider was monitoring infection prevention and control practices, some improvement was needed to ensure that all relevant issues were identified particularly relating to the challenges posed by some bungalows.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There was inadequate fire containment measures in four of this centre's buildings. There was inconsistency amongst staff and one resident's PEEP on how to support the resident to evacuate from the centre in the event that they refused.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The security of medicines storage in two bungalows was found to require improvement. One medicines' press contained some expired items. Some items were listed on a resident's list of regular prescribed medicines to be used twice a week but per the resident's administration records, they were not recorded as being used consistently in recent months.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had personal plans in place which were subject to multidisciplinary review and used a person-centred planning process. Residents of this centre did not have personal plans in an easy-to-read format.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had specific health care plans in place and were supported to avail of national screening services.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff members had undergone relevant training in de-escalation and intervention while guidance was also in place on how to support residents to engage in positive behaviour. Restrictive practices in use were being assessed and reviewed regularly.

Judgment: Compliant

Regulation 8: Protection

Guidance was available for staff on how to support intimate personal care. All staff had undergone relevant safeguarding training.

Judgment: Compliant

Regulation 9: Residents' rights

During this inspection some delivery men were seen to enter one bungalow without knocking or announcing themselves to staff or residents before entering. Such instances had the potential to impact residents' privacy in their homes.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially 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 Liscarra OSV-0007862

Inspection ID: MON-0036768

Date of inspection: 03/10/2022

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: • Staffing levels are reviewed on a continuous basis and we continue to endeavour to provide consistent staffing across all centres. • PIC continues to review rosters with night manager following receipt of same for each pay-period. • The PIC has access to planned rosters at all times. • There is a core staff team that work in the designated centre. • Head of Integrated Services (HOIS) and Assistant Director of Nursing (ADON) meet with the night mangers bi-weekly to review the roster. • Ongoing recruitment continues.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Fire Safety building compliance remains a high priority for the BOCSI and BOCSILR. • There is ongoing engagement between the BOCSI and the HSE in relation to advancing the plan for Bawnmore. This includes the Chair of the Board and CEO met with Head of Operations Disability Services (following: Both the HSE) in August. Head of Operations Disability Services requested a revised high-level plan for Bawnmore that focused more on decongregation given that this is the national policy. This was submitted both to HSE national and local on 31st August 2022. A follow up meeting with Head of Operations Disability Services took place on the 1st September. HIQA Regional Manager was updated on 15th September 2022. The Director of Services submitted an updated plan on the 25/10/2022 to the HSE.	

• Risk assessment in place for fire safety and all preventative measures continue to be followed within the designated centre.
• Hourly checks at night in unstaffed houses. Risk assessment in place and reviewed quarterly.
• The Fire alarm system has been designed, installed, commissioned and certified to L1 standard and is in compliance with Irish Standard 3218:2013/Code of practice for design and installation of fire alarm systems. ·
• The Emergency Lighting system has been designed, installed, commissioned and certified as in compliance with Irish Standard 3217:2013/Code of practice for emergency lighting systems.
• First responders training has being completed with relevant staff. Specialised PPE has been purchased for the first responders.
• Training on the use of the Fire Safety PPE has being completed with first responder staff 19.10.2021 & 21.10.2021.
• Fire equipment fitted to relevant areas. Including Flash lights, high vis jackets and fire extinguishers.
• Boiler and Controls test and Certification of the System (held with facilities manager).
• Additional training has been completed for fire drill committee and first responders.
• All floor plans checked, updated and reflective of the actual.
• Emergency Key Boxes for exit doors removed – as not required due to mag lock system.
• Review of staff attendance in Fire Training completed. Fire familiarisation with the Fire Department has been completed.
• Drawings (Map) for pre fire risk card have been completed and forwarded to fire department. Outlining high risk areas, fire hydrants, static water supplies etc.
• Facilities manager prioritises works in terms of individualised fire controls required in each bungalow.
• Wireless alarm system put in place,
• A folder with floor layout of each bungalow available .This is available to the fire department in the event of a call out.
• Emergency phone sourced and installed for additional first responder on days.
• Fire drill template has been updated with assistance from fire drill committee, to include evacuation to both outside exits where same is in place and responders go to the exit with their emergency equipment.
• Scenarios of a fire in a different part of the bungalows in the designated centre with varying amounts of staff at different times completed by Fire Officer and included as part of fire drill committee training.
• Standard location for fire equipment has been agreed and equipment sourced.
• Regular Fire Drills by day & night.
• Automatic opening of doors in the event of fire.
• Fire Extinguishers checked and audited
• Egress plans in place for all residents.
• Fire alarm connected to 3 fire phones to promptly alert first responders of alarm.
• Fire alarm was operational on last check.

• Electrical checks continue for both day and night. All non-essential electrical equipment

unplugged at night in terms of compliance .
• Fire Safety Register in place and reviewed by the PICs

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• Resident's activities discussed with all staff members at the weekly house meetings on the 26/10/22 and the 02/11/22.
• Staff have been informed the importance of residents partaking in meaningful activities on and off campus.
• Activity records will be reviewed monthly by the PIC, any actions to improve activities and documentation will be addressed with staff following each review.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The PIC met with the assistant facilities manager on the 28.10.2022 and decoration and maintenance issues were identified.
• There is a system in place for addressing maintenance issues as they arise. These are prioritized by the PIC and are scheduled in consultation with facilities management.
• The facilities manager meets with the HOIS and ADON bi-weekly.
• A log of MRF's is insitu that is returned to the PIC each month identifying works that were completed.
• Ovens cleaned in all houses in the designated center, one new oven purchased for one of the houses.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk

management procedures:
• The PIC discussed with all staff, if they have concerns regarding if one resident was having an impact on another resident. All staff stated they do not feel there is concerns or safeguarding issues with any resident within the designated center and reflected on their information that was delivered on the day of inspection.
• The PIC reviewed the person supported daily unit notes, AIRS forms and residents weekly meeting minutes and found no evidence to indicate that the person supported in question was impacted by another resident.
• A risk assessment is in place for a resident for behaviors of concern, this is monitored on a quarterly basis by the PIC or before the quarter if required.
• A monthly review of AIRS forms is completed by the PIC.
• Weekly staff meetings take place.
• Support and Supervision takes place for all staff on a quarterly basis.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The gaps in the cleaning were discussed at the weekly staff meeting on the 26/10/22 and the 02/11/22 and PIC discussed the importance of completing the cleaning schedule.
• PIC discussed with night managers to reiterate to night staff to discuss the importance of completing the cleaning schedule.
• PIC completed a walk about on the 04.10.2022 and replaced hand sanitiser which were out of date or where the date could not be identified.
• Meetings with ECO cleaning company management take place quarterly with the ADON , HOIS and Facilities manager.
• Facilities managers are completing spot checks in the designated centre to ensure standards are being met by ECO.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• PEEP's plan for one resident updated to reflect evacuation plan.
• PEEP's plans for all residents reviewed and discussed with all staff at weekly meetings held on the 26/10/22 and the 02/11/22.
• Fire Safety building compliance remains a high priority for the BOCSI and BOCSILR.
• There is ongoing engagement between the BOCSI and the HSE in relation to advancing the plan for Bawnmore. This includes the following: Both the Chair of the Board and CEO

met with Head of Operations Disability Services (HSE) in August. Head of Operations Disability Services requested a revised high level plan for Bawnmore that focused more on decongregation given that this is the national policy. This was submitted both to HSE national and local on 31st August 2022. A follow up meeting with Head of Operations Disability Services took place on the 1st September. HIQA Regional Manager was updated on 15th September 2022. The Director of Services submitted an updated plan on the 25/10/2022 to the HSE

• Risk assessment in place for fire safety and all preventative measures continue to be followed within the designated centre.
• Hourly checks at night in unstaffed houses. Risk assessment in place and reviewed quarterly.
• The Fire alarm system has been designed, installed, commissioned and certified to L1 standard and is in compliance with Irish Standard 3218:2013/Code of practice for design and installation of fire alarm systems. ·
• The Emergency Lighting system has been designed, installed, commissioned and certified as in compliance with Irish Standard 3217:2013/Code of practice for emergency lighting systems.
• First responders training has being completed with relevant staff. Specialised PPE has been purchased for the first responders.
• Training on the use of the Fire Safety PPE has being completed with first responder staff 19.10.2021 & 21.10.2021.
• Fire equipment fitted to relevant areas including Flash lights, high vis jackets and fire extinguishers.
• Boiler and Controls test and Certification of the System (held with facilities manager).
• Additional training has been completed for fire drill committee and first responders.
• All floor plans checked, updated and reflective of the actual.
• Emergency Key Boxes for exit doors removed – as not required due to mag lock system.
• Review of staff attendance in Fire Training completed. Fire familiarisation with the Fire Department has been completed.
• Drawings (Map) for pre fire risk card have been completed and forwarded to fire department. Outlining high risk areas, fire hydrants, static water supplies etc.
• Facilities manager prioritises works in terms of individualised fire controls required in each bungalow.
• Wireless alarm system put in place,
• A folder with floor layout of each bungalow available .This is available to the fire department in the event of a call out.
• Emergency phone sourced and installed for additional first responder on days.
• Fire drill template has been updated with assistance from fire drill committee, to include evacuation to both outside exits where same is in place and responders go to the exit with their emergency equipment.
• Scenarios of a fire in a different part of the bungalows in the designated centre with varying amounts of staff at different times completed by Fire Officer and included as part of fire drill committee training.
• Standard location for fire equipment has been agreed and equipment sourced.
• Regular Fire Drills by day & night.
• Automatic opening of doors in the event of fire.
• Fire Extinguishers checked and audited
• Fire alarm connected to 3 fire phones to promptly alert first responders of alarm.

• Emergency lighting in place • Fire alarm was operational on last check. • Electrical checks continue for both day and night. All non-essential electrical equipment unplugged at night in terms of compliance . • Fire Safety Register in place and reviewed by the PICs. **The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations**

Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: •• Medication audits were completed on the 06.10.2022 in the designated center. • Medications that had expired were returned to the pharmacy on the 05.10.2022. • PIC discussed with the staff nurses the importance of ensuring no out of date medications are stored in the medication presses. • PIC discussed with the staff nurses the importance of having the keys to the medication press on their person at all times when in the house. • Kardex of one resident updated by the G.P to remove an item that was not required to be on same. • Walkabout with the facilities manager took place on the 28th of October and plans were put in place to move the medication presses from the kitchen in two of the houses in the designated center.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • PIC will develop easy read personal plans for each resident in the center. This will be completed in liaison with the SLT.	
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Visitors to the centre were reminded of the mandatory wearing of masks when entering a house, they were also reminded of the importance of ringing the door bell and announcing themselves before entering the residents home.	

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/12/2022
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/12/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in	Substantially Compliant	Yellow	30/11/2022

	circumstances where staff are employed on a less than full-time basis.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/12/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/12/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/05/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in	Not Compliant	Orange	31/05/2023

	accordance with the statement of purpose.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	17/10/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/11/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/05/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where	Substantially Compliant	Yellow	31/10/2022

	necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 29(4)(a)	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 any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	31/10/2022
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.	Substantially Compliant	Yellow	31/10/2022
Regulation 05(5)	The person in charge shall make the personal plan	Substantially Compliant	Yellow	31/12/2022

	available, in an accessible format, to the resident and, where appropriate, his or her representative.			
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, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	31/10/2022