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:	Community Residential Service Limerick Group A
Name of provider:	Avista CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	12 February 2025
Centre ID:	OSV-0003939
Fieldwork ID:	MON-0046250

About the designated centre

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

Group A Community Residential Service provides full-time residential services to twelve service users. These services are provided in three community houses in Limerick. The designated centre provides services to individuals with mild and moderate levels of intellectual disability. The aim of the designated centre is to improve the quality of life of residents through a person centred approach, ensuring they are encouraged, supported and facilitated to live as normal a life as possible in their local community. The three community houses are two-storey semi-detached houses, with front and back gardens. Each resident has their own private bedroom, some with en-suite facilities. Communal space is available in each house for residents which includes kitchen-dining rooms and sitting rooms. In addition, each house has bathroom facilities, office space/staff bedroom and utility rooms. Each house is staffed by social care staff with access to nursing staff as required. A staff member works sleepover duty in each house at night.

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
Wednesday 12 February 2025	11:30hrs to 18:40hrs	Elaine McKeown	Lead
Wednesday 12 February 2025	11:30hrs to 18:40hrs	Kerrie O'Halloran	Support

What residents told us and what inspectors observed

Following the receipt of unsolicited information to the office of the Chief Inspector, this unannounced risk inspection was completed to meet with residents who were in receipt of residential services in the designated centre on the day of the inspection. The systems in place to ensure effective safeguarding of residents, staffing and the governance and management of the designated centre were the focus of this inspection. This centre was registered as a designated centre in February 2017. The most recent renewal of the registration of this designated centre had occurred on 14 February 2023. This designated centre was last inspected in August 2023 by inspectors of social services on behalf of the Chief Inspector.

The inspectors were aware prior to the inspection taking place that the person in charge would not be available during the inspection. The person participating in management was available to provide documentation, additional information and to meet with the inspectors on the day. All residents in receipt of services in the designated centre were met by either one or both of the inspectors at different times during the day. All three houses that are part of this designated centre were visited during the inspection.

On arrival at the first house the inspectors were greeted by a staff member and introduced to one resident who was being supported in their home due to illness. The other three residents had already left to attend their day services. During the morning one inspector spent some time talking to this resident in the sitting room. The resident spoke about the other residents they lived with and how they liked their home. They showed the inspector their bedroom which was seen to be decorated in a personalised manner. The resident drew the inspector's attention to a door which was not in use but connected to the adjacent house which was also part of this designated centre. The resident told the inspector how they did not like this door as they can hear the noise from another resident's bedroom located on the other side of the door. The inspectors acknowledge that this door was seen to be locked on the day of the inspection and the resident had many personal items in front of the door as it was not in use. However, this will be further discussed in the quality and safety section of this report.

Later in the afternoon the inspectors met with the other three residents who lived in the same house after they returned from their day service. A resident asked an inspector if they would like to see their bedroom. The resident was very proud of their bedroom and it was seen to have pictures and personal items displayed. The resident had an en-suite bathroom, which was noted to require some maintenance as the flooring was slightly lifting in places and the shower area was tired in appearance. Similar issues with the main bathroom in this house were also observed by inspectors.

The three residents spoke to the inspectors about how they enjoyed meeting with friends, visiting local shops/ cafes and restaurants. One resident was very proud of

working in a local retail outlet each week. The residents had recently enjoyed a planned overnight stay in a hotel to celebrate a milestone birthday of two residents living in the designated centre. The residents also expressed some concerns they had relating to staffing in the designated centre. Residents outlined how they did not like the number of different staff that were supporting them in their home. The inspectors acknowledge circumstances outside of the provider's control had occurred in the weeks and months prior to this inspection. This will be further discussed in the capacity and capability section of this report.

One inspector met with the four residents who lived in the adjoining house in the early afternoon. One resident who was enjoying their retirement, was preparing to go for a walk in the local community. They spoke about their interest in attending sporting events and other social activities. They indicated to the inspector that they were happy living in their home. Another resident invited the inspector into their bedroom to see upgrade works that had been completed to their en-suite. They were very happy with the finished result and informed the inspector they had no issues of concern. They had celebrated a milestone birthday with family and friends recently and enjoyed attending their day service each week day.

Another resident spoke with the inspector in the sitting room as they were watching a film. They outlined how they missed a named member of staff who was expected to return to work the week after this inspection. The resident also spoke about changes that had been made to the core staff team in the house where they lived. The resident explained that they were still getting used to the change as they had been living in the house for many years and had enjoyed being supported by familiar staff in the past. The fourth resident shook the inspector's hand when introduced. The staff member present assisted the resident to outline some of their interests which included sports. As the resident had just returned from their day service they were busy with their evening routine and only engaged with the inspector briefly.

While visiting this house, the fire alarm was emitting intermittent beeping sounds. The inspector was informed the alarm had been activated the previous night. The code to re-set the alarm was not effective at the time the inspector was in the house. One resident in this house informed the inspector they were not happy listening to the sounds coming from the fire panel which was located in the hallway near the sitting room where the resident was located at the time. This was discussed with the person participating in management during the inspection. This person then contacted the facilities team to seek to get the issue resolved. This will be further discussed in the capacity and capability section of this report.

Both inspectors visited the third house later in the afternoon. They were greeted by a staff member who was part of the core staff team and familiar to the residents. One inspector met all four residents living here and spent some time talking to them. Residents appeared very happy and relaxed and the member of staff also joined part of the conversations. Residents spoke to the inspector about their family and friends and also about the day services they attended. Residents here enjoyed watching television, listening to music, going for walks and shopping in a nearby shopping centre. One resident told the inspector that their independence was very

important to them. They were very proud telling the inspector they have their own key for their front door and leave themselves into their home independently.

It was evident meeting and speaking with the residents that they were able to voice their concerns relating to issues that affected them. However, following a review of incident records and complaints in one house delays in responses or gaps in documentation did not provide assurance residents satisfaction to responses from the provider to the issues raised were adequately addressed. For example, five residents had been supported to make complaints in December 2024 after they had voiced their concerns during a residents meeting in November 2024. However, while actions documented included supporting residents with changes to the staff team, on the day of this inspection residents informed both inspectors that the number of different staff coming into their homes was not nice. Residents reported finding it difficult to remember all the names of the relief/agency staff supporting them and instances had occurred where residents felt they were not been supported. For example, on 15 December 2024 a resident reported their annoyance which included relating to the lack of interactions from a named staff member on the 12 December 2024. An incomplete incident form relating to the same incident was reviewed by one inspector. The details that were documented indicated that a notification should have been submitted to the Chief Inspector. Four other incident forms were also reviewed in the same house. The incidents had occurred between 13 October 2024 and 5 January 2025. One inspector noted missing information pertaining to some of these incidents included an incomplete incident form relating to an incident that had occurred on 12 December 2024 on a transport vehicle. Another incident form had no details documented of immediate actions taken by staff on 5 January 2025 regarding an electrical appliance. This was discussed during the inspection and in the feedback meeting the day after the inspection. A retrospective notification was submitted by the provider to the Chief Inspector regarding the incident of 12 December 2024 that a resident had self reported. This will be further discussed in the capacity and capability section of this report.

The inspectors observed professional interactions between the staff members and the residents they were supporting during the inspection. It was evident residents were more familiar with some staff on duty. For example, one relief staff member had only worked on one previous occasion in the designated centre. Another staff was part of the regular relief panel and was known to the residents they were supporting. Two other staff on duty were part of the core staff team. However, one of these had only recently commenced working in this designated centre.

During conversations with residents and staff members, as well as a review of documentation it was evident that references to residents finances were not reflective of the adults in receipt of services in this designated centre. The repeated reference to "pocket money" was found to be used both verbally and in written format. While residents did have money management plans and financial assessments, gaps in some documentation was also evident. For example, the financial assessment for one resident did not have a date of completion, did not have completed information regarding the money available each week to the resident after they had paid their bills and had outdated information regarding contributions from 2017. Another resident's money management plan which had

been reviewed on 7 October 2024 and signed by the resident, referred to their independence with day-to day money management including their bank card. It was documented the resident did require some assistance from staff. However, the last five questions on the money management plan were not completed. This resident lived in the house where on the day of the inspection, it was observed by inspectors that all residents living in this house had their bank cards stored in one location by staff. The consent of residents for this practice was not evident on the day of the inspection. This was discussed during the inspection. The inspectors were informed it was not deemed a restriction on residents accessing their finances but the rationale for the practice to be occurring was not evidenced at the time of the inspection to be documented for each individual for whom the practice was been used.

In summary, residents living in one of the houses informed inspectors that they did not have any concerns or voice any issues relating to their home or the supports they were being provided with. However, this was not found to be consistent with the experiences of the residents living in the other two houses. The inspectors were not assured the rights of residents were being consistently upheld which included listening to the voice of residents or responding in-line with the provider's safeguarding policy when concerns have been raised by a resident. The process expected by the provider for staff to respond to concerns or allegations of abuse is outlined in Section 10 of the provider's current safeguarding policy which included time lines for reporting once a concern is raised. In addition, equality pertaining to the residents human rights was not evident in particular when referring to personal finances as residents " pocket money". Following a review by inspectors of internal audits and the most recent annual review there was evidence of repeated findings and actions not been addressed during 2024.

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, the findings of this inspection found evidence that further improvements were required by the provider to ensure residents were being consistently supported, concerns raised by them were responded to and managed in line with the provider's own policies and procedures.

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. However, following a review of the actions identified in the March and August 2024 internal six monthly audits some actions were noted to be repeated. The auditors

documented at the start of both of the internal audits, that while one house was visited during each audit, all actions identified were to be applied across all of the three houses. Following the March 2024 audit 20 actions were listed to be addressed by 30 March 2024. The August 2024 internal audit listed 33 actions to be addressed by 30 December 2024. There were a number of repeat findings in these audits with evidence on the day of this inspection that some actions had not still not been adequately addressed. These included inconsistent or non progression of residents goals, improvements were identified to be required in residents personal information files and the risk register required further review. In addition, an inspector noted in the August 2024 audit, the auditor had documented the importance to ensure language used in all sections of documents are reflective of a rights based approach. However, the same audit referred to residents "pocket money" when reviewing if residents money is safely accounted for.

The inspectors acknowledge some actions had progressed or where evidenced to have been completed on the day of the inspection. These included adaptations to bathroom facilities in one house to better suit the needs of residents living there and upgrading of the en-suite facilities in another house for one resident.

While the provider did strive to ensure minimal staffing levels were being maintained as outlined in the statement of purpose, the impact on residents due to the inconsistencies of familiar staff supporting them was evident for some residents in this designated centre. Residents outlined to both inspectors situations where staff were unfamiliar with their routines and where residents were unsure of who the staff member was that was supporting them on occasions in their homes.

The provider did have systems in place for residents and the staff team which included supports from management and the staff in the two houses adjacent to each other also provided support if required. Centre specific information was available to staff members however, in one house this was not accessible to one staff at the start of their shift in the afternoon. The staff member informed one inspector that they were unable to gain access into the staff office as they did not know the access code to gain entry. The daily handover and other staff communications were locked in the office. A staff member from the adjoining house assisted the inspector to gain entry into the office.

Regulation 15: Staffing

The core staff team was comprised of a person in charge who worked full time in the designated centre and seven social care workers. An additional three regular relief staff were also available to work in the designated centre when required. At the time of this inspection, the inspectors were informed that four core staff were on unplanned or extended leave.

The inspectors had requested the actual and planned staffing rosters from the

beginning of January 2025 to two weeks after the inspection day. In one house, not all of these rosters were available for the inspectors to review on the day of the inspection. The roster folder provided to the inspectors to review did not contain all of the requested rosters for this time line. The inspectors had provided a document to the person participating in management at the initial meeting on the day of the inspection of documents that would be required for review during the inspection.This included planned and actual rotas from 30 December 2024. The purpose of the request was to establish the number of staffing supports/ regular relief or agency staff that were supporting residents during this period.

An inspector reviewed a planned roster from 16 February to the 22 February 2025 which indicated in total three internal relief staff would be working in the designated centre. The actual roster from the 25 January to 1 February was reviewed. The staffing supports for residents during this period included shifts being covered by agency staff and internal relief staff. One house had one agency and two internal relief staff, another house had four agency and two internal relief staff while the third had three agency and one internal relief. During the same period the person in charge was unavailable and the person participating in management was responsible for the governance and management of the designated centre. The inspectors acknowledge that the provider had ensured residents who had been unwell were supported by staff during the day in their home. This was additional to the regular staffing resources required in the designated centre and had resulted in the requirement for agency staff to provide support.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had identified mandatory training for staff working in this designated centre which included fire safety, safeguarding and understanding and responding to challenging behaviour (URBC). On review of the training matrix provided to the inspectors, not all staff had completed training in safeguarding. One staff had been out of date since September 2024. Three staff had not completed refresher training in URBC. The inspectors acknowledge that the person participating in management followed up during the inspection with the staff member who was required to complete refresher training in safeguarding.

The inspectors were informed staff members were responsible to ensure all on-line training was completed and up-to-date, with the person in charge to maintain oversight. The person in charge was also responsible to schedule mandatory training, some of which was delivered by the provider in a central location. The inspectors were informed a process was in place where monthly updates on training were to be provided from the designated centre. However, the gaps in training identified during the inspection did not provide assurance the system in place was

effective in monitoring and addressing gaps in training and refresher courses for the staff team in a timely manner.

The provider was not able to demonstrate on the day of the inspection if the staff team had being supported with supervision in line with the provider's own policy. While the findings of an internal audit in both March and August 2024 indicated staff were meeting formally twice a year with local management, inspectors were unable to review a schedule of these supervisions for the core staff team that were reported by the person participating in management to have taken place during 2024 for the team or a planned schedule for 2025. Records of supervisions that inspectors were informed that had taken place were held in a central location by the provider. While inspectors were offered the opportunity to visit the location, this was not done on the day of the inspection as the focus was to meet and spend time with the residents living in this designated centre. This will be actioned under Regulation 23: Governance and management

Judgment: Not compliant

Regulation 23: Governance and management

While the provider had systems in place for the oversight of the designated centre, review the quality and safety of care being provided and ensure an annual review and internal audits were being completed, further improvements were required.

- Repeated actions had been identified on internal audits and still remained unresolved at the time of this inspection. For example, in March 2024 it was identified there was inconsistent tracking of personal goals for residents. The action required clearly outlined monthly entries were to be documented. In August 2024 evidence of progress with personal goals was found not to be consistent and in the annual review report of October 2024. On the day of the inspection following a review of four personal plans this was also a finding of the inspectors.
- Gaps in training were identified in both of the internal audits during 2024, with the auditor referring to URBC training for staff remaining an issue. The provider had requested that all mandatory training was in date by 30 September 2024.
- Issues had also been identified with personal information files of residents being dis-organised, containing out of date information and ensuring the language used in all sections of these files were reflective of a rights based approach. However, inspectors found these issues remained unresolved at the time of this inspection.
- An annual review had been completed in October 2024. The report indicated that a safe and good quality service was being provided. Residents were able to articulate their views and were very independent. It was documented that feedback from residents included that they would like regular staff to be supporting them in their homes. A number of issues raised by residents

during their residents meetings had not been addressed or processed as complaints. The reviewer requested residents to be supported to make a complaint regarding these issues. This will be further discussed under Regulation 34: Complaints.

- The annual review of 2024 also noted input from family representatives had not been included/available for either the 2023 or 2024 annual report. While the reasons were documented this process is a planned report and two consecutive years of no input was highlighted by the reviewer.
- The reviewer also referred to the internal audits being completed in one of the houses but all actions must be implemented in all three houses that are part of the designated centre. This was not evident to be occurring at the time of this inspection. One of the recommendations made by the reviewer was that the person in charge was to complete a monitoring log to manage audit findings. An action identified in the August 2024 audit required enhanced oversight and the documenting of progress on actions being addressed. While the provider had systems in place such as quality and safety audits and a monitoring log of actions in progress in the designated centre, the effectiveness of the oversight was not evident at the time of this inspection as some actions remained unresolved with no update on barriers being encountered or actions being completed. This included findings on the day of the inspection relating to personal plans and goals for residents. For example, an action in the March 2024 audit outlined the requirement for "entries on progress to be updated for each goal. Monthly entry required". The date for this action to be completed was 30 March 2024. This was not evidenced to be occurring in the personal plans reviewed during the inspection. For example, one resident had no update on the progression of their goals from February 2024 until June 2024, another resident had identified a personal goal in November 2024 and no update on the progress to date had been documented at the time of the inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not ensured the Chief Inspector had been notified in writing within three working days of all adverse incidents. Following a review of incidents in one of the houses from October 2024 to the date of the inspection, it was evident at least two incidents had not been reported in line with regulatory requirements. The incomplete documentation of the incidents by staff at the time and subsequently by management did not provide assurances that effective systems were in place to demonstrate the actions taken, the rationale for the non reporting of the incidents or measures to reduce the risk of a similar incident occurring. The inspectors acknowledge two retrospective notifications were submitted regarding

these specific incidents following this inspection.

There had also been a delay in the submission of a notification where a resident had been adversely impacted by the actions of a peer on 27 November 2024. A retrospective notification had been submitted by the provider following a review of the incident.

On the day of the inspection, the fire alarm panel in one of the houses was heard to be emitting intermittent beeping sounds. One inspector was informed a resident had activated the fire alarm the previous evening. The staff member outlined that the same resident could act in this manner when they were being supported by staff that were unfamiliar to them. The inspector was also informed other occasions in the weeks prior to the inspection had arisen where the alarm had been activated by the same resident. The inspector was informed as this activation was known to be caused by the individual and turned off it was not being documented as an incident occurring. The inspector was informed previous similar activations had also not been documented as occurring, and the fire panel would be re-set immediately. However, the Chief inspector had not been informed of any occasions where the fire alarm was activated other than for the purpose of fire practice, drill or test during 2023 or 2024 in the quarterly notifications as required by the regulations.

The inspectors were also unable to review incidents that had occurred in one of the houses prior to 13 October 2024, as the provider had changed their recording /documentation process and the previous records were not available for review on the day of the inspection. The person participating in management outlined the change in process that had occurred but the incident log prior to October 2024 which had been used in the house could not be located by the staff team in the office at the time the inspectors were in this house.

This regulation was also found to be non compliant in the August 2022 inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had ensured a complaints process was in place which was accessible to residents in the designated centre. However, the satisfaction of the complainant was not always documented. This included three complaints made by three residents on 15 December 2024 about planned changes to the staff team. While actions to support the residents were documented, which included supporting them with staff transitions, the satisfaction was not documented and residents spoke of this change to both inspectors during the inspection. Another complaint regarding food options in November 2024 did not document the satisfaction of the complainant.

It was evidenced also that staff did not support residents to make a complaint following residents meetings. For example, on 28 November 2024 the meeting notes referred to residents making a complaint about plans by the provider relating to

regular staffing. The action log of the meeting templates remained blank and there was no evidence of the issues being followed up. The residents were not supported to make a complaint until 15 and 17 December 2024 regarding this issue.

In addition, two additional issues raised by residents in the September 2024 residents meeting were identified in the 2024 annual report as requiring to be managed as complaints. These were completed retrospectively, but inspectors were not assured all complaints were being logged and investigated promptly once an issue was raised by a resident.

Judgment: Not compliant

Quality and safety

Overall, residents living in this designated centre were supported to be independent in many aspects of their lives. This included remaining in the designated centre with no staff support. One resident has been provided with a power pack to assist them with their independence to mobilise in their wheelchair. While the pack required repair on the day of the inspection, the resident outlined to inspectors the positive impact the power pack had for them in their daily life when it was working. This resident also spoke of a change to the transport vehicle which was easier for them to access and facilitated them to go out with peers if they wished to do so. Previously, the resident would have had to get a taxi and follow their peers from the house to a community location or social outing.

Residents enjoyed meeting peers in their homes, enjoying social events together and celebrating important events such as a birthday party the evening before the inspection.

Four personal plans were reviewed during the inspection. Permission was sought from one of these residents who was present in the house at the time. Another personal file was not reviewed when the resident had clearly documented their wishes to be consulted before any person looked at their file. As the resident was not in the house at the time to obtain their permission this file was not reviewed by inspectors. Of the files reviewed there were gaps evident in some documentation. This included reviews of personal plans, goals, money management plans and individual risk assessments.

The records of some residents daily activities were also reviewed. While residents were supported to be independent and engage in activities of their choice, some activities which residents were documented as having interests in had been infrequent. Preferred activities were clearly outlined, and the likes and dislikes of each resident were recorded. One of the resident's plans identified major interests as shopping, cinema and shows/music. However, on review of the resident's activity

record for January 2025, shopping had only been completed twice and the resident had not attended the cinema. Another resident had only met a friend on one occasion during January 2025. The inspectors acknowledge that poor weather during the month did impact some activities taking place.

Regulation 13: General welfare and development

The records and the observations of the inspectors throughout the inspection indicated that residents were supported to have a meaningful day, and to be occupied in accordance with their preferences and abilities. One resident was employed in a retail outlet, others attended day services in line with their expressed wishes. For example, one resident had requested to attend their day service at a later time and this was reviewed to organise mornings where the resident could avail of a lie-in.

Residents were being supported to enjoy a good quality of life, and had access to numerous activities, both in their home and out in the community. Activities included listening to music, shopping, cinema, meeting friends in local cafes, going for drives and going for walks.

Residents were also being supported to maintain links with the wider community including local services such as hairdressers. Personal relationships important to residents were also evidenced to being supported.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the houses supported the assessed needs of the residents. All three houses were observed to be homely and decorated to reflect the personal interests and tastes of the residents living there. Upgrades to bathroom facilities in two of the houses were evident and had been reported by residents as being happy with the works completed. There was evidence of actions from the August 2022 inspection having been addressed which included the patio area to the rear of one house.

However, not all areas were found to be in a good state of repair. In particular in one of the houses where damage was evident to the flooring in the main bathroom and an en-suite. Duct tape was observed to be in place in another house between

the sitting room and hallway flooring.

The inspectors acknowledge that the provider had taken actions regarding the storage of salt bags outside the front doors of two of the houses following the August 2022 inspection. This included discreet boxes placed near the front doors, these were observed to contain supplies of salt on the day of the inspection. However, the same two front doors also had an additional large bag of salt outside as inspectors arrived. While there had been a recent adverse weather event, the storage of the excess salt bags required further review to ensure the residents homes were maintained externally in a similar way to their neighbours.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had ensured a risk management policy was in place. Risks identified within the designated centre and for individual residents had been subject to regular and recent review. Actions had been identified in both of the provider's internal audits regarding the review of risks within the designated centre.

The inspectors also reviewed individual risk assessments for four residents. On review of one of these assessments for a resident controls were documented regarding them being away from the designated centre. The risk assessment had been reviewed on 4 November 2024 but was unclear what the rationale was for one control measure which was documented as requiring staff to phone the resident every hour while they were out in the community to ensure they were well. The inspectors spoke with this resident during the inspection and asked if this was required and taking place. The resident responded by saying it was not taking place. This was discussed at the feedback meeting following the inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a comprehensive assessment of need was completed for each resident. The inspectors viewed four of the residents' files. Where a need was identified, care and support plans were developed. These were seen to be kept under ongoing review with some showing evidence of being updated as required. However, two of the personal plans reviewed by the inspectors contained old documentation dating back a number of years. This had been identified in both of the provider's internal audits during 2024.

The person in charge also completed a yearly audit of these plans. The person

participating in management was also part of this review. Action plans were identified for key workers to complete. An inspector reviewed one of these audits completed by the person participating in management and these actions were seen to be completed. For example, one resident's personal plan required some archiving of records and this was seen to be completed. However, another personal plan had been subject to a review in October 2024, out of date information pertaining to financial entitlements from 2017 remained in the file. Also, there were gaps in some of the documentation contained within this same file, including a financial assessment that was not dated or completed in full.

Residents were supported to identify and set goals for the future in their yearly planning meetings. Residents were seen to be part of these meetings. Goals had been set for residents and residents had an identified key worker to support them to achieve these goals. However, some goals required review as no progress notes had been recorded. For example, a resident had a goal in place that they wished to purchase a foot spa and book relaxation therapies. This goal had been set in November 2024 and no progress was evident with this goal. Another resident also had a goal identified in November 2024 to support their mental health. No details/updates had been documented since the goal had been identified and agreed. As previously mentioned in this report, the lack of documentation on the progress of personal goals had been identified in both of the provider's internal audits during 2024.

Judgment: Substantially compliant

Regulation 8: Protection

There were no open safeguarding plans at the time of this inspection. The inspectors were informed a safeguarding plan had been closed on 6 January 2025. Inspectors were unable to review all documents pertaining to this safeguarding incident as sections such as the preliminary screening were being stored in a central location by the provider which is as outlined in the provider's current policy for the protection and welfare of vulnerable adults and the management of allegations of abuse, May 2024.

However, on the day of the inspection, the inspectors were only able to view the interim safeguarding plan. This contained only limited details, it did not outline the details of the alleged incident, the preliminary screening was not available for review in the safeguarding folder or the resident's file, the actions taken in reporting to relevant persons/ agencies or the closing of the safeguarding plan were not documented. The safeguarding plan was discussed at the staff meeting in January 2025 where staff were informed it was closed. While the inspectors acknowledge the provider did offer the opportunity for the inspectors to review documentation pertaining to this safeguarding incident in the central location, this was not

completed on the day of the inspection by the inspectors.

As inspectors had identified five incomplete incident forms in one of the houses and were unable to review incidents logged prior to 13 October 2024 in the same house, a review of the current safeguarding policy was undertaken after this inspection. The policy clearly outlines the processes to be followed if a concern arises in a designated centre. This includes if a concern relates to a designated centre it must be reported to the Health Information and Quality Authority (HIQA). Two of the incidents that had been documented since October 2024 including an incident that had been categorised as neglect on the incomplete incident form in December 2024 had not been reported to the Chief Inspector prior to this inspection.

The inspectors were not assured effective control, reporting and review systems to protect residents from all forms of abuse were in place in this designated centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents living in this designated centre were independent and were able to exercise choice in their daily lives with minimal staff supports. Inspectors met with all of the residents living in the three houses that are part of this designated centre. From speaking with residents in two of the houses and a review of documentation, it was evident that there were times the concerns raised were not addressed. The adverse impact on some residents with the departure of familiar staff was still an issue at the time of this inspection. The actions to support residents with the transition of staff required ongoing input at the time of this inspection.

Residents had voiced their concerns at residents meetings and through complaints regarding the increased number of unfamiliar staff supporting them in their homes in recent months.

One resident outlined an issue for them to the inspectors regarding a locked door into the adjoining house in their bedroom. This was described by the resident as impacting them as they could hear the resident in the adjoining house, "closing the drawers". The inspectors acknowledge that the provider indicated during the feedback meeting that they were unaware this was an issue for the resident.

In one house all banks cards belonging to the residents were being stored in a central locked location. However, the rationale for this was unclear and not clearly documented in money management plans for some of these residents. As previously mentioned in this report one of these residents was independent in managing their finances including their bank card and required some support from staff. The consent of residents to this practice was not documented at the time of this inspection.

Not all residents had been supported to have a complete money management plan

documented. For example, one resident 's money management plan had been reviewed in October 2024. It was found to be incomplete on the day of the inspection, There were no details of how much money was available each week to the resident after they paid their bills.

The reference by staff members both verbally and written regarding residents " pocket money'' was not in line with their human rights. Residents should be consistently afforded equality by staff supporting them when using terms relating to their finances. In addition, the use of sheet of paper on the 11 and 12 of February 2024 to record residents finances did not evidence respecting their privacy and dignity. Due to an audit of residents finances in one house the expenditure sheets were not available for staff to complete. However, the loose sheet which was located in the communication book, had details of each residents initials and how much money was in their purse. This was not reflective of considering residents right to privacy.

Judgment: Not 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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Community Residential Service Limerick Group A OSV-0003939

Inspection ID: MON-0046250

Date of inspection: 12/02/2025

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 registered provider will continue to ensure that staffing levels are maintained as outlined in the statement of purpose. The registered provider will ensure that ongoing recruitment of staff to replace vacant posts continues. The PIC will continue to allocate familiar staff on each shift where possible.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC will ensure that all outstanding staff training is completed in line with schedule. The registered provider will review staff training requirements to ensure they are reflective of staff training needs. The schedule of staff supervision meetings is now available in the staff office in the centre.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider and PIC will ensure a system is in place for ongoing oversight of personal plans, including audits, to ensure that they reflect the personal wishes and needs of residents and that support plans are in place as required. The Quality, Safety and Risk department will support the PIC and staff team to ensure personal plans are updated in line with each person's will and preference.

The PIC will ensure a system is implemented to monitor and ensure that progress on personal goals is documented in line with policy. Training and support for keyworkers will be provided by the Service Transformational lives team leader and the PCP enabler.

The PIC will ensure that all outstanding staff training is completed in line with schedule.

The registered provider will review staff training requirements to ensure they are reflective of staff training needs.

The registered provider will ensure guidance is provided to staff in relation to management of complaints, including completion of required documentation.

The registered provider will ensure that residents will be supported to enhance their skills in self advocacy and raising issues of concern or complaints. This will be facilitated by Social Worker and CNM2.

The registered provider and PIC will ensure that the views of family representatives will be included in the report of the annual audit of quality and safety of the centre.

The registered provider & PIC will ensure that progress on completion of actions identified at audit is available and accessible in the centre.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The registered provider will ensure that systems to ensure all notifications are submitted in line with regulation are in place.

Incidents will be reviewed by PIC and PPIM to ensure that incidents requiring notification are identified promptly and reported in a timely manner.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The registered provider will ensure guidance is provided to staff in relation to management of complaints, including completion of required documentation.

The registered provider will ensure that residents will be supported to enhance their skills in self-advocacy and raising issues of concern or complaints. This will be facilitated by Social Worker and CNM2.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider will ensure that ongoing maintenance is completed in the centre on a priority basis within the available budget, as required.

The registered provider and PIC will ensure that excess salt to de-ice driveways will be moved to the shed as soon as practical after weather events.

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:
The registered provider and PIC will ensure a system is in place for ongoing oversight of personal plans, including audits, to ensure that they reflect the personal wishes and needs of residents and that support plans are in place as required.
The Quality, Safety and Risk department will support the PIC and staff team to ensure personal plans are updated in line with each person's will and preference.

The PIC will ensure a system is implemented to monitor and ensure that progress on personal goals are documented in line with policy.

Training and support for keyworkers will be provided by the Service Transformational lives team leader and the PCP enabler.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The registered provider, PPIM and PIC will ensure review of incidents arising in the centre to ensure
- that all safeguarding concerns & reports are reported in line with policy and regulations.
- that all incident forms are completed in full.
- that a copy of open safeguarding plans is held in the personal plan.

Risk assessments in relation to safeguarding risks for each person of concern will be also held in the personal plan.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC will ensure regular meetings with residents continue and these capture the views of residents of any issues of concern to them are documented, including actions to be taken and supports provided.

The Registered provider and PIC will ensure that documentation regarding the storage of bank cards and terminology related to residents' personal finances is updated to ensure it is reflective of a human rights-based approach.

The registered provider & PIC has ensured a review of residents' money management plans to ensure they are completed in full.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/04/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/06/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	30/12/2025

	state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2025
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	30/04/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of	Not Compliant	Orange	30/04/2025

	abuse of any resident.			
Regulation 31(3)(b)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which the fire alarm equipment was operated other than for the purpose of fire practice, drill or test of equipment.	Not Compliant	Orange	30/04/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	19/03/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Substantially Compliant	Yellow	30/05/2025

	needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	19/03/2025
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.	Not Compliant	Orange	19/03/2025