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:	Le Cheile
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	14 May 2025
Centre ID:	OSV-0004752
Fieldwork ID:	MON-0046452

About the designated centre

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

Le Cheile consists of two large one-storey detached houses located on a campus setting on the outskirts of a city. The centre has undergone renovation in the past two years to ensure the environment is suitable to the assessed needs of the residents. The centre can support twelve residents. The centre can provide full-time residential care for residents over the age of 18 of both genders with intellectual disabilities. Each resident in the centre has their own bedroom and other facilities throughout the centre include dining rooms, living rooms, kitchens and bathrooms amongst others. Residents are supported by 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
Wednesday 14 May 2025	10:10hrs to 18:45hrs	Kerrie O'Halloran	Lead
Wednesday 14 May 2025	10:10hrs to 18:45hrs	Lucia Power	Support

What residents told us and what inspectors observed

This was short term announced adult safeguarding inspection completed within the designated centre Le Cheile. The inspection was completed as part of an inspection of a number of designated centres based on the Bawnmore campus.

It was found through observation in the designated centre, conversations with staff and management of the centre and meeting eleven of the residents that lived in the centre, that residents were relaxed in their home, generally enjoyed a good quality of life and were supported by staff to be involved in activities both in the centre and in the local community.

The centre comprises of two large bungalows that could accommodate six residents in each. On the day of the inspection twelve residents were living in the centre. The centre is located on a campus on the outskirts of Limerick city which has a range of amenities. Both bungalows have undergone a full refurbishment. One bungalow had been renovated in 2023, while the second bungalow had been renovated after the last inspection that took place in October 2023. Both bungalows had been decorated to meet the individual needs of the residents. The houses were homely, clean and welcoming. Each house had a visitor's room so residents could spend time with family and friends in private if requested.

After the introductory meeting with the person in charge, an inspector visited one of the bungalows. Here the inspector was greeted by two staff members. The inspector was asked to sign the visitor's book on entry to the house. The centre had the complaints officer and safeguarding designated officer displayed on a notice board in the kitchen. A staff member showed the inspector around the house and informed the inspector that some residents were completing activities outside of the centre, while others were in their home. One resident was on a day trip to a beach. The inspector met five of the residents during their time in the centre. Some residents were enjoying reflexology, while others were watching some television. Staff spoken with were knowledgeable of the needs of the residents. Staff were overheard to be kind, caring and respectful towards residents, for example a member of staff was preparing a drink for a resident and they were speaking to them throughout this. The residents in this house did not verbally communicate with the inspector, however the staff informed the inspector that the residents living here were very happy. Since moving into the house one resident had started to verbally communicate with staff, saying many new words and this was a new experience for both the staff and the resident.

Later in the afternoon an inspector had the opportunity to visit the second bungalow that made up the designated centre. Again this house was seen to be well furnished throughout, clean and very homely. Some of the residents here had taken part in pet therapy earlier in the day, an activity which was enjoyed by the residents. The complaints officer and designated officer were displayed in the hallway of the centre. The inspector met six residents living here. One resident showed the

inspector their bedroom with the support from staff on duty. The resident showed the inspector an important photo album along with their personal items which they were very proud of such as their art work. Another resident had returned from a trip out in the community. They told the inspector they liked visiting the local shopping centre and the barber. The inspector asked these two residents if they felt happy and safe in their homes to which they replied that they did. Other residents here who did not communicate verbally used methods such as facial expressions and vocalisations. The staff appeared to be knowledgeable of the residents needs.

Staff members told the inspector of how they ensured that residents' rights were respected by offering choice and enabling residents to have autonomy and control in respect of their daily lives. They told the inspector of how residents' meetings were held weekly to ensure that residents had opportunities to inform the running of the house and to provide residents with information. A staff member informed the inspector of activities that were being held each week for the month of May, this included a trip to Knock. The management of the centre also informed the inspector of a council on quality and leadership (CQL) accreditation that the provider would be completing next week as part of their ongoing commitment for good care and support services for residents living in the centre.

The inspector had the opportunity to meet five members of staff during the inspection. It was evident that each resident was being supported to have person-centred care and engage in meaningful activities. In one house it was identified that some residents may like a bath and the previous renovations had not included this. However, there were plans in place to put a bath in one of the house's bathrooms.

The centre had three transport vehicles available which could be used for outings or activities that residents could chose to do. This ensured that residents could access individual outings in line with their own choices or as part of a group. Some activities residents enjoyed in their homes included listening to music and watching television, reflexology, table top activities, foot spas, pet therapy and parties or relaxing in the garden areas of both houses. Residents also enjoyed a number of activities in the local community which included going to the swimming, shopping, going to the local hairdressers or barbers and visiting the beach. Residents also enjoyed eating meals out in local cafes and restaurants.

Overall it was seen that residents had a generally good quality of life living in Le Cheile. The next two sections of the report present the findings of this inspection about 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

This section of the report describes the governance and management arrangements and how effective these were in ensuring a good quality and safe service. The

centre is currently registered until January 2027. Le Cheile has been renovated over the past two years and both houses were seen to be well laid out to meet the needs of the residents.

Bawnmore campus is made up of five registered designated centres. Out of the five centres registered there are four that currently have restrictive conditions attached. The Chief Inspector os Social Services attached these restrictive conditions to come into compliance based on the provider's time bound plan. The provider made these commitments in the plan they submitted to the chief inspector dated 5 December 2023.

The Chief Inspector carried out an inspection of all five centres on the one day and as part of this inspection process the overall plan for the five centres was reviewed.

The provider was making good progress, for example, two houses were completed to a very high standard taking into account the individual needs of residents and one house being refurbished to the specification of each resident to support their individual needs. The provider had also purchased a house in the community to transition a resident and a new development of three units in the community had started.

It was also observed and noted on the day of inspection that residents were well supported and there was positive interactions from staff. Residents were also accessing their community on a more regular basis and this will be discussed in the individual inspection reports linked to the campus.

The provider was seeking accreditation from an external body in relation to the providers on going work for quality improvement for residents.

There was good evidence of oversight, governance and commitment from the provider. A member of the senior management team spoke about each house on campus and the profile of each resident, she demonstrated a very good understanding of the changing needs of residents and spoke about the evolving culture moving towards a social model of support.

It was also evident from speaking with residents that they were involved in the decisions about their new homes. This will also be discussed in the individual reports. The provider has been afforded time to come into compliance as issues relating to fire and premises have been significant and it was evidenced that works are being carried out in accordance with the plan. The provider demonstrated commitment to enhancing the quality of life of residents and this was observed and noted in all centres on campus along with very good supports that was evident from staff and management. This was observed on the day of inspection by noting the smiles, gestures and interaction from residents.

Overall, this inspection found that systems and arrangements were in place to ensure that residents received care and support that was safe, person-centred and of good quality. Le Cheile did not have a restrictive condition attached at the time of this inspection.

Regulation 15: Staffing

The registered provider had ensured the skill-mix and staffing levels allocated to the centre were in accordance with the residents' current assessed needs. An inspector reviewed the staff rosters from April to May 2025 and was informed there was no staff vacancies at the time of the inspection. A clinical nurse manager (CNM) had been recently recruited for one of the houses in the designated centre and they were due to commence their role in the coming weeks. The person in charge discussed with an inspector the value of consistent staffing within both houses and how this consistency had a positive impact for residents.

Furthermore, an inspector observed staff engaging with residents in a respectful and warm manner, and it was clear that they had a good rapport with residents and a thorough understanding of the residents' needs.

Judgment: Compliant

Regulation 16: Training and staff development

From the training records reviewed for the designated centre a total of 26 staff members worked regularly in the designated centre. This included nine relief staff. The person in charge discussed with the inspector that the centre had consistent staffing in place.

The inspector reviewed the training matrix which indicated staff had completed a range of training courses to ensure they had the appropriate levels of knowledge skills and competencies to ensure their safety and safeguarding them form all forms of abuse. These trainings included children’s first and safeguarding of vulnerable adults. Staff had also completed training in managing actual and potential aggression (MAPA).

All of the staff team had completed training in fire safety and manual handling. Where refresher training was required staff had been identified and would be booked into the next available training dates.

The person in charge provided effective support and formal supervision to staff. Staff informed the inspector that informal support was provided on an ongoing basis. Formal supervision was completed for all staff in line with the provider's policy.

All staff spoken with on the day of the inspection had good knowledge and awareness of the provider's policies and standards around safeguarding. Staff in both houses identified to the inspector a safeguarding folder that was in place that

contained training links, information on the designated officer, the provider's policies and a safeguarding induction document that was used for all new staff.

Judgment: Compliant

Regulation 23: Governance and management

The provider was found to have suitable governance and management systems in place to oversee and monitor the quality and safety of the residents in the centre. There was a management structure in place. Each house had a CNM in place who supported front line staff, along with the person in charge. The person in charge was supported in their role by the assistant director of nursing within the provider organisation.

There were good arrangements such as regular management meetings which were seen to discuss areas of incidents, complaints and safeguarding. The person in charge had ensured weekly team meeting were taking place. The inspector reviewed the team meetings from April to May 2025.

The provider had ensured the designated centre was subject to ongoing review to ensure it was resourced to provide effective delivery of care and support in accordance with the assessed needs of the residents and the statement of purpose. This included monthly and quarterly audits which the person in charge completed and had oversight of to ensure actions were addressed in a timely manner. These audits included financial audits, infection prevention and control audits, fire audits and incident returns audits. The person in charge also completed a quarterly unannounced night inspection audit. In these audits the person in charge reviewed documentation such as the fire folder and policies and spoke with the night staff on duty around their knowledge of the residents' communication needs, behaviour support plans and safeguarding.

The provider's most recent annual review was completed in March 2025 and had consulted with residents and their representatives. The review contained positive feedback from residents

Actions had also been identified as part of this review, such as a bath to be installed in one of the houses for residents. it was also identified that the person in charge ensure that all staff are aware how to access the safeguarding folder on a shared drive, this was demonstrated in both houses during the inspection.

The provider had also completed six-monthly unannounced visits to the centre. these had been completed in April 2025 and October 2024. These audits were seen to have action plans in place with actions completed within the identified time frame. For example, the October 2024 unannounced visit identified actions around the health care supports for a resident and these were seen to be completed.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of service for the residents living in the designated centre. This inspection found that systems and arrangements were in place to ensure that residents received care and support that was safe. This inspection focused on safeguarding practices in the designated centre. There were no immediate safeguarding concerns found on this inspection.

The registered provider ensured effective measures were in place for the ongoing management and review of risk. There was a risk register in place that identified specific risks for the designated centre. Individualised specific risk assessments were also in place for each resident. It was seen by the inspector that these risk assessments were regularly reviewed and gave clear guidance to staff on how best to manage identified risks.

The designated centre had consistent staffing in place. From speaking to the person in charge and the staff team this had a positive impact for residents continuity of care. The staff teams in both houses were found to be knowledgeable of the residents assessed needs. Staff supported, encouraged and promoted a range of activities both in house and in the local community.

Overall, the inspector found that the residents were supported to enjoy a good quality of life and that they were in receipt of good quality and safe services. The person in charge and staff team were making efforts to ensure the residents were happy, engaging in activities they enjoyed and striving to achieve the goals and lifestyle desired by residents.

Regulation 10: Communication

The registered provider had ensured that each resident was assisted and supported to communicate in accordance with their assessed needs and wishes.

Residents were supported to choose activities through the use of visual schedules and accessible information. The centre had displayed pictures in a communal living area of activities residents had recently completed, such as, going shopping or out to a café. Each week these would be updated and older pictures placed in an activity file for the residents which they could review. One resident told the inspector that they liked these pictures.

Some residents met with during the inspection were non-verbal, or limited verbal communication. These residents were supported to communicate through visual

expressions and vocalisations or some words. The inspector saw kind and caring interactions between residents and staff, and staff were able to use their knowledge of residents and their routines to promote responses. For example, the inspector observed a staff member assisting a resident with a drink and then informed the inspector the resident would be going for a rest as the resident indicated through their body language that they were tired. The staff member told the inspector that as the resident was aging they supported the resident to have a rest during the day when required.

Each resident had a communication passport in their personal care plans, along with an accessible communication booklet. These booklets contained all information about the residents communication needs, along with their likes and dislikes.

Judgment: Compliant

Regulation 17: Premises

The designated centre comprised of two bungalows, both of which had been refurbished in the past two years. Both houses were seen to be warm, clean and homely. Each house was well furnished and had adequate storage for the needs of the residents. The designated centre was designed to provide mindful storage for residents' medical equipment where needed.

Each resident had their own bedroom and they were seen to be decorated with their personal items displayed. Residents in both houses had access to a visitor's room where they could spend time with family and friends in private.

As mentioned previously in the report, the staff informed the inspector that one house had plans to add a bath to one of the bathrooms as this was an addition that the residents would like in their home. There are plans for this to be completed in the coming months.

Judgment: Compliant

Regulation 26: Risk management procedures

The safety of the residents was promoted through risk assessment, learning from adverse events and the implementation of the provider's policies and procedures. It was evident that incidents were reviewed regularly and learning from such incidents was discussed at weekly team meetings and informed practice. There were systems in place for the assessment, management and ongoing review of risks in the designated centre. For example, risks were managed and reviewed through a centre specific risk register and individual risk assessments. The risk register and individual

risk assessments were reviewed regularly by the person in charge. Each risk assessment had control measures in place to mitigate the risk. Residents had individual risk assessments in place where a risk to their wellbeing or safety was identified, these were seen to be kept under review. For example, a resident with dementia had a risk assessment that identified their changing behaviour may lead to a negative impact for others. This risk assessment had identified controls to support both the resident and their peers. Such controls, that included a dementia care plan, were in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Three of the residents' personal plans were reviewed on the day of inspection. The inspector saw that each of these files contained a personal information guide and person-centred care and support assessment which detailed residents' health and social care support needs. These personal plans had been reviewed regularly and updated within the last 12 months while residents' personal planning meetings had taken place.

The residents' personal plans reflected input from various health and social care professionals, including psychology, occupational therapy, behaviour support and speech and language therapy. Residents were support through regular multidisciplinary team meetings.

Residents had documented goals in place. Each resident had key workers in place to support them in achieving their goals. Residents were seen to have achieved some goals such as going on overnight trips, attending concerts and hurling matches. Each resident had a photo book in place documenting their achievements and outings that they had completed. A staff member informed the inspector that these personal photo books were updated regularly to reflect new activities residents completed and enjoyed. In one house a resident had completed a goal and it was clearly documented that parts of the goal that did not go well for the resident, a member of staff explained to the inspector that staff were now aware of this for the resident in future.

Weekly person supported review meetings took place for each resident in the designated centre. At these meetings the person in charge along with the staff nurses and health care assistants working with the resident would review such things as the residents' activities, safeguarding, incidents, health care needs, assistive technology and medical appointments that had taken place or upcoming appointments for the residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff in this centre had received training in de-escalation and intervention and were aware regarding residents' behaviour support plans. This was effective in ensuring that staff could respond to incidents of behaviour of concern in a manner which was effective in protecting residents and ensuring that their rights were upheld.

Residents who required positive behaviour support plans had these in place. One such plan was reviewed and was found to be written in a person-centred manner. This plan had been reviewed in November 2024 and clearly identified behaviours of concern, triggers, and strategies for staff to implement. The plan included the communication needs of the resident. Residents that did not require a behaviour support plan had guidelines in place for staff to follow to support residents. staff spoken with on the inspection were knowledgeable of the plans in place for residents.

Some restrictive practices were used in the designated centre. The person in charge maintained a restrictive practice log which outlined a list of restrictive practices used in each house. These had been recently reviewed in May 2025. Consideration was given to ensuring that restrictions were the least restrictive and therefore least impacted on residents' rights. Since the last inspection of the designated centre it was seen that these restrictions had slightly reduced.

Judgment: Compliant

Regulation 8: Protection

The registered provider had ensured that residents were protected from all forms of abuse. The inspector reviewed documentation relating to the last safeguarding incident that had taken place in November 2024. The person in charge had ensured that the provider's policy was followed in this incident. A review meeting had taken place with the designated officer and other relevant members of management. This incident was closed on the day of the inspection.

The staff spoken with during this inspection demonstrated a good awareness of how and who to report safeguarding concerns to. Staff were aware of what a safeguarding incident may look like through different types of abuse. A staff member in one house also identified that if a safeguarding incident was to occur in the future they would be aware of any interim safeguarding plan if required.

Training records provided indicated that all staff had completed relevant safeguarding training.

Weekly staff meetings were occurring in each house of the designated centre and safeguarding was a running agenda item. The person in charge informed the

inspector that although were no current open safeguarding plans in the centre, safeguarding would continue to be discussed at meetings to promote staff awareness.

Residents' files contained up-to-date intimate care plans which detailed measures that staff should take to ensure that residents' dignity, privacy and autonomy were upheld when in receipt of personal care.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to maintain contact with their families and friends, and visitors were welcomed to the centre. A visitors log was provided in the centre and the inspector was asked to sign this when they arrived at the centre.

Residents attended weekly residents meetings. Residents were supported by the management and staff team in making decisions and choices. For example, residents had access to day service staff three days a week in one house and four days a week in another house. This staffing in place supported residents to attend a range of activities that they preferred. Some residents enjoyed going out shopping and visiting local cafes. While others enjoyed reflexology, pet therapy and baking. Residents have individualised and group activities planned for each week which reflected their interests and hobbies. The staff informed the inspector when a resident declined an activity this was also respect and supported by the staff on duty.

During the October 2023 inspection, it was identified that residents in this designated centre had bank accounts with the one banking organisation and that there was no evidence to support that the residents were involved to select a bank of their choosing, were consulted and had the freedom to exercise control in relation to this. The provider had implemented actions outlined in the compliance plan response sent to the Chief Inspector following the October 2023 inspection. This included ensuring residents' bank statements were scanned and retained in the personal financial file of the relevant residents. The provider also made available to the Chief Inspector following this most recent inspection communication and other records which demonstrated that the provider had raised issues related to residents' bank accounts to other bodies since the October 2023 inspection. During the current inspection, it was indicated that matters related to residents' bank accounts remained unchanged and that this had been identified as being a restriction on residents. The provider had completed a review of the "Policy on the handling of the personal assets of adults supported by the services". This review included the addition of a restrictive practice decision making record within the policy which acknowledged aspects of the policy are restrictive for residents. However, the policy

also referenced that restrictions were being kept to a minimum while endeavouring to ensure adequate arrangements were in place to protect resident's finances.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Le Cheile OSV-0004752

Inspection ID: MON-0046452

Date of inspection: 14/05/2025

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 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The BOCSILR Policy on the Handling of the Personal Assets of Adults Supported by the Services includes a permission form which supports people to opt in or opt out of support from the BOCSILR in the management of their personal assets. • No resident is restricted from managing their own personal assets if they choose to opt out of support from the BOCSILR. Residents may choose to manage their personal assets independently, with a decision supporter or another person outside of the services should they choose to. • In order to support people to make an informed decision information is provided to them regarding the nature of the support that the BOCSILR can offer to them in terms of the management of their personal assets. • At present the BOCSILR have identified one suitable deposit account and one suitable current account through which support can be offered in a safe manner both for the person supported and for staff. • The BOCSILR Policy on the Handling of the Personal Assets of Adults Supported by the Services clearly sets out the limitations on direct access to personal assets inherent in the use of this type of account in order to ensure full transparency when a person is choosing to opt in or opt out of support. • Every effort is made to mitigate the impact of the restrictions on direct access to personal assets inherent in the use of this type of account and these are set out in the policy. • Limitations on direct access to personal assets inherent in the use of this type of account as well as those in place to minimize the vulnerability to misappropriation of funds are not notified to the regulator as restrictions as each person support has the right to opt in or opt out of support. • The BOCSILR is committed to exploring all alternative accounts that may facilitate less restrictive direct access to personal assets for people supported who opt in to support from the BOCSILR. In this regard the engagement with the assisted decision making department with the HSE seeking guidance in assisting residents in relation to banking arrangements was commenced on 11/11/2024. Engagement with banking institutions	

has also been perused to identify possible suitable banking products that would be a less restrictive alternative for residents within the service.

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 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	31/12/2026