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:	Saoirse
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-0004767
Fieldwork ID:	MON-0046603

About the designated centre

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

This designated centre is based on a large campus setting within the environs of Limerick city. There has been a number of re-configurations of this designated centre in recent years. Currently the centre is comprised of two bungalows and is registered to support a maximum of eight residents. Adults both male and female with a diagnosis of intellectual disability are supported in this designated centre. One bungalow can accommodate four residents. This bungalow consists of four individual bedrooms and was being re-designed and re-configured to meet residents' needs. The second bungalow has four individual bedrooms, a kitchen, dining room, sitting room, visitor room, two bathrooms and additional toilet area, utility and staff office. There is also an enclosed garden area with parking at the front of the property. Residents are supported by a staff team comprised of nurses and health care assistants by day and night. Residents can avail of the on-site services such as day services, swimming pool, gym, church and multidisciplinary team support.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 14 May 2025	10:10hrs to 18:45hrs	Robert Hennessy	Lead

What residents told us and what inspectors observed

There were four residents living in the centre on the day of the inspection. The centre was registered for eight residents and for two buildings. One of the buildings of the centre was closed on the day of the inspection and was being renovated to a high standard as part of the registered provider's programme of works. There were four residents in the centre and the inspector spoke with all four residents on the day of the inspection. Residents were happy in their home and appeared relaxed and comfortable with the support they received from staff.

The inspector had an introductory meeting with the person in charge when arriving at the centre. The person in charge discussed the plan that was underway to renovate one of buildings in the centre to make it to four self-contained areas for residents and that a purpose built home was being built in another part of the city to house the other residents. The person in charge introduced all the residents to the inspector. One resident was waiting for the inspector at the door and greeted them as they entered. The other residents were working with an art therapist on art projects with the assistance of staff working with them.

Following the introductory meeting the inspector undertook a walk around of the premises. Areas of the premises were dated and required attention. The house was due to be closed later in the year and residents moving to purpose built modern houses. Issues regarding the premises are outlined under Regulation 17. The sitting room in the centre had new furniture and seating purchased for it. The residents' bedrooms were personalised and decorated in a suitable manner for the residents. Residents had access to hoists and accessible bathrooms to meet their changing needs.

The inspector spoke with all four residents. All four residents greeted the inspector in a warm manner and shook the inspector's hand. Residents spent time in the purpose built outdoor area as the weather was good on the day of inspection. One resident showed the inspector raised beds that had been sourced for them to complete their gardening work. All residents indicated to the inspector that they were happy living in the centre and that they got on well with staff. Residents were seen to go out with staff to the shop for items they liked to purchase. One resident was seen watching horse racing on the television and was really enjoying it. Staff informed the inspector that these were horse races that were recorded and played online on the television. One resident spent much of the morning in an enclosed outdoor area as they liked to stay out in good weather. The inspector was informed that the residents would be attending bingo in a communal part of the campus during the afternoon.

The inspector spoke with the staff members during the inspection and with three staff members working directly with the residents on the day of the inspection. The staff were seen to interact kindly and respectfully with the residents and were attentive to their needs during the day. One staff member spoke about supporting a

resident and their changing health needs. There was extensive measures put in place to support this resident. The resident did not wish to undertake the regular process put in place to have their personal goals identified for the year, but these goals were put together for the resident by staff in another format which worked well for the resident.

The residents were provided with good support from staff and were happy with the activities they undertaking. The residents in the centre did not spend much time speaking with the inspector but appeared very content in the designated centre. Staff working there were working in the best interests of the residents and their goals.

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

Capacity and capability

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 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 of Social Services 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 were evident from staff and management. This was observed on the day of inspection by noting the smiles, gestures and interaction from residents.

The staff working in the designated centre on the day of the inspection had received appropriate training in relation to their roles. The governance structure was appropriate for the centre. While adequate staffing arrangements were mostly in place, it was not clear whether at some points of the day during evening hours if the correct supports could be provided to residents that required two-to-one support.

Regulation 15: Staffing

The registered provider had ensured that core staff vacancies were filled in the centre. There was an activation staff member in the centre on the day of the inspection. The staff team were regular in the centre and knew the residents and their needs well. Staff spoke respectfully about the the residents and how they provided support to them. There were no staff vacancies in the centre.

As with the findings from the last inspection, it was unclear whether people named on the roster were maintained in the designated centre. It was not clear whether the staff that worked from 20:30 to 23:00 was always available to the residents in this centre when residents required two staff to support them. The night time staffing resources were being managed by the manager of the overall campus on nights.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector viewed a training matrix for the staff that were named on the designated centre's roster including the relief staff. This matrix showed that staff were provided with training appropriate to their roles. The person in charge was ensuring that there was good oversight of the training needs of staff.

The schedule for staff supervision was given to the inspector which showed that supervision had taken place and the schedule for the rest of the year was in place. This was taking place once a quarter in line with the registered provider's policy.

Staff members were asked how they accessed information such as relevant legislation and standards that related to working in the centre. Staff had access to an online platform which contained all this information and also had access to go online to find any documents they required.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were in place to ensure that service being provided was appropriate to the residents' needs. The annual review was completed in March 2025 and the unannounced provider inspections had taken place in March 2025 and September 2024. This showed that the registered provider was maintaining good oversight of the service being provided in the designated centre and the governance and management systems in the centre were effective.

The annual review identified areas of improvement required by the service. The annual review contained information on how residents were consulted and how they were involved in initiatives in the centre. There was evident in this review of what residents had achieved during the year such as one resident visiting Sweden to have a holiday with a family member there. Unannounced six monthly inspections were being completed by the provider which again identified actions to improve the centre.

A schedule was in place for resident meetings to take place on a weekly basis. These meetings included information on safeguarding and easy to read information was also available to residents in relation to safeguarding. Staff team meetings in the designated centre also discussed safeguarding and it was also a topic discussed in staff supervisions.

Judgment: Compliant

Quality and safety

There were no safeguarding concerns in the centre on the day of the inspection. Residents' personal plans contained accessible information in relation to safeguarding. These personal plans contained information on how residents communicated and how they liked to be communicated with.

Residents' rights were respected and upheld in the centre and the centre was resident led in the way it was run. Residents had goals for the year created and these goals were realistic and reviewed. Risk was well managed in the centre and

measures were in place for safeguarding of residents. Residents had positive behaviour support plans in place when they required support in this area.

The part of premises that the residents were living had aged and would not be suitable on a long term basis. It was acknowledged that the residents were due to move out of the centre in the months following the inspection and the premises would no longer be used as part of the centre.

Regulation 10: Communication

Residents had a communication passport in place to support their communication needs. These documents were pocket sized which meant they could be carried around with the resident if required. These documents described residents' likes and dislikes, how they liked to communicate and how they wanted to be communicated with. The personal plans of residents contained information on communication with the residents and guidance on how staff may support them in this area.

Easy-to-read documentation and accessible documentation was available to residents throughout the centre and personal plans had easy to read documentation contained in them.

Residents had access to Internet and had smart devices, such as televisions, to use in the centre.

Judgment: Compliant

Regulation 17: Premises

The premises had been a concern during the last inspection. It had been explained in the previous compliance plan submitted that four residents would move into a different designated centre while one of the bungalows in the centre was thoroughly renovated. This was underway and this bungalow had much of the works completed. The bungalow that four of the residents are living in was due to close with a new purpose built bungalow being built in another location.

The outdoor area had an enclosed outdoor space for residents to enjoy during finer weather. There were raised beds in this outdoor area for residents to use for gardening.

The bungalow that the residents were currently living in had new furniture recently bought for the sitting room and residents bedrooms were seen to be decorated in a personalised manner. However, much of the bungalow was outdated and had such issues as:

- Areas of flooring throughout the centre were worn.
- The covering on one of the floors was rising a small area of a sitting room.
- Paint was chipped on doors and the surroundings throughout the centre.
- Cabinet doors in the kitchen had pain removed and were worn.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Assessments and personal plans for the four residents were viewed. The assessments and personal plans had been reviewed in the last 12 months. The multidisciplinary team had been involved in the review of residents' personal plans. One resident required support with their health needs and staff had undertaken a person-centred plan to support the resident in this area. The residents had easy-to-read information on safeguarding in their personal plans.

Annual goals for the residents were being created as part of a person-centred planning process. Documentation reviewed in relation to this showed that realistic goals had been created and reviews of these goals were taking place. Examples of activities undertaken were setting up a gardening area for a resident. This had been completed and was in use on the day of the inspection. One resident had also been on a foreign holiday to visit family members.

Staff spoke about one resident being supported to access the community to access a male hair stylist. The person had previously used a person that visited the centre. This was, according to staff, working really well for the resident.

It was evident that residents were undertaking other activities outside of the person-centred planning process and these activities were recorded on activity charts.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were no chemical, physical or environmental restrictions in the designated centre on the day of the inspection. Residents that required support had clear guidance for staff on how to work with the residents in this area. The staff had all received training in the area of de-escalation and intervention.

Judgment: Compliant

Regulation 8: Protection

There were no safeguarding issues in the designated centre on the day of the inspection. All staff had received training in the area of safeguarding. The staff spoken with were aware of how to recognise instances of abuse and how this may be dealt with. Staff members spoke with residents in a respectful manner on the day of inspection and were seen to respect and protect residents' privacy. For example, staff were seen to knock on doors and seek permission to enter residents' bedrooms. Residents had intimate care plans in place to support them at the level required in this area. It was evident that the care and support in the designated centre was resident led.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had choice around which activities they would undertake each day, activities and goals were adapted for the residents in line with their needs. Residents had a weekly meetings to contribute to the running of the centre. Evidence that residents had given consent was clear in the personal plans.

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.

Requests had to be made for residents to access their money. While a staff member spoken with indicated that this process could take up to a week, they did highlight that residents were never short of money. Residents in the centre were supported to use their bank cards as independently as possible for example they may not be able

to use at automated teller machine (ATM) themselves but may use the tap function for contact less transactions and take a receipt.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had a suitable risk management policy in place. This policy had identified and contained the control measures for the specified risks under the regulation. A risk register was maintained for general risks in the centre and the residents had individual risk assessments in relation to how they were supported. These risk assessments had been reviewed in the previous 12 months. Incidents were recorded and reviewed in the centre. One resident in particular was undergoing changing needs in the centre, there was clear evidence that the risk assessments for this residents were being reviewed in order that they may continue to undertake the activities they enjoyed.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not 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
Regulation 26: Risk management procedures	Compliant

Compliance Plan for Saoirse OSV-0004767

Inspection ID: MON-0046603

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • There is a planned roster in the Designated centre. • Where there have been incidences when the 20:30- 23:00 may not be filled due to staff shortage this support has been provided by the night manager. • A risk assessment is currently in place and reviewed each quarter or as required. • Ongoing recruitment continues. Shortlisting currently in progress. Interviews scheduled for week commencing 7th July.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Maintenance meeting held on 03/06/2025 with facilities to prioritise minor maintenance to be completed in the context of the overall Bawnmore plan. This included a walkabout of the Designated centre with the ADON to inform this discussion. • Progress on the plan submitted to HIQA in respect of Fire safety, building upgrade and Decongregation is advancing as set out in the update submitted to HIQA. The intention is that all residents in this Designated centre will reside in high quality homes once this plan is fully realised. • The Person in Charge will continue to complete quarterly Infection Prevention and Control Quality Improvement Tool to identify any issues with the premises, which will then be escalated to maintenance and ADON.	

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 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	30/09/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2027
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	Substantially Compliant	Yellow	31/12/2026

	and control in his or her daily life.			