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:	East Limerick Services
Name of provider:	Corlann
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	09 April 2026
Centre ID:	OSV-0004779
Fieldwork ID:	MON-0048092

About the designated centre

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

East Limerick Services consists of three detached single storey houses, located close together on the outskirts of a village. The designated centre can provide a full-time residential services for up to 12 residents of both genders with intellectual disabilities who are over the age of 18 years. Individual bedrooms are available for residents and other facilities throughout the houses of this centre include bathrooms, sitting rooms, kitchens, dining rooms and staff rooms. Support to residents is provided by the person in charge, clinical nurse managers, staff nurses, social care workers and care assistants. Staff provide support both by day and night to residents.

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
Thursday 9 April 2026	09:45hrs to 17:30hrs	Elaine McKeown	Lead

What residents told us and what inspectors observed

This inspection was an unannounced focused regulatory inspection to review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and the National Standards for Adult Safeguarding (2019). Safeguarding of residents is an important responsibility of a registered provider and fundamental to the provision of high quality care and support.

Based on the findings of this inspection, the inspector found that residents who lived in the centre had a good quality of life. Residents had choices in their lives and were frequently involved in activities they enjoyed. The person in charge and staff were focused on ensuring that a safe service was provided to residents and that residents were informed about recognising harm. However, there were a number of issues identified during the inspection. These included ensuring consistency in relation to the privacy and dignity of residents, ensuring all risks were identified and adherence to control measures by the staff team. These will be outlined further in this section and in the quality and safety section of this report.

This designated centre was last inspected in January 2024. While the provider had outlined actions to attain compliance with the regulations following that inspection, there were some repeat findings which indicated compliance was not being consistently attained with relevant regulations in some areas of the designated centre. This included non-adherence to the protocols of locked storage of food thickening agents and the personal information of residents.

On arrival the inspector was greeted by a staff member and informed the clinical nurse manager was the senior staff on duty. The inspector was introduced to the clinical nurse manager who facilitated the inspection throughout the day. The person participating in management also came to the designated centre. The person in charge was unavailable on the day of the inspection. However, all requests made by the inspector for information and documentation were responded to by the staff on duty. Both the clinical nurse manager and the person participating in management were familiar with the assessed needs of each of the residents and demonstrated their awareness of ensuring the safeguarding of residents.

The inspector met with 11 of the residents living in the designated centre during the inspection. The inspector visited all three houses on at least two occasions during the day to ensure they could meet with as many residents as possible at times that best suited their routines. One resident declined to meet with the inspector and this was respected. The residents who were spoken to included two residents who were transitioning into the designated centre. One of these residents spoke of plans to bring more personal items and they had been visited by the occupational therapist to ensure the correct aids were in place for them. They explained their bed had been re-positioned to better suit their assessed needs. The resident had enjoyed

going to the cinema the day before the inspection with peers and liked spending time in the day room engaging with group activities. The other new resident had attended their day service and was relaxing with peers in their sitting room when introduced to the inspector in the afternoon. They were observed to be smiling while listening to music. They stated they had enjoyed their day and was very happy in their new home. Two other residents present at the time were observed to engage in conversations with this resident.

The inspector met another resident who had undergone planned surgery recently. They spoke about their experience and were looking forward to going back to their regular day service routine the week after this inspection to meet with their friends. Staff had arranged for the this resident's hairdresser to come to them in the designated centre to get their hair done as they were unable to travel to the premises. The resident was very happy to have this done in advance of going back to their day service. The inspector met with the resident who had moved into their own apartment since the previous inspection. They were smiling, stated they were very happy with their accommodation. They explained they were planning to create raised flower beds in their private garden area in the coming months. They also had a visual schedule which they explained to the inspector had important pictures of activities and locations. This included equine therapy and a local shop.

Another resident who engaged regularly throughout the day with the staff team was observed to be supported with the responses given to them. These responses were consistent with the information documented in the resident's positive behaviour support plan. The resident was listened to by the staff engaging with them but also provided with clear and concise answers to the questions they were asking of staff. This assisted with helping to reduce the anxiety experienced by the resident and staff reported it was working well.

Most of the residents met with during the day were happy with their homes, knew the staff who were supporting them and were engaging in regular activities of their choice. However, one resident was upset upon meeting the inspector initially. Their plans had changed as a result of ongoing protests that were taking place on the road network near the designated centre. This was outside the provider's control but the resident was unable to attend their day service as a result of the protest. Also a planned visit to relative had to be postponed. This had caused upset to the resident. The staff present offered re-assurance, provided evidence on their mobile phone of how the road network was blocked and listened to the resident as they spoke about a number of issues. The inspector met with the resident again later in the afternoon where they spoke about other issues including their bathroom facilities where they did not feel they had adequate privacy. The inspector was informed by the resident they did not like having to use their shared bathroom when they were unable to lock the bathroom door access from the second bedroom. The locks present only facilitated the bathroom door to be locked from inside each resident's bedroom, not internally from the bathroom. This was observed by the inspector during the walk around. In addition, the resident strongly voiced their discontent at not being able to attend a day service they had attended prior to becoming unwell during 2025. They missed their friends and while they understood the reason was due to them requiring oxygen therapy they still wished to return. The inspector was informed the

clinical nurse manager and person participating in management were to meet with the resident after the inspection to discuss their concerns with them.

Additional issues relating to privacy and dignity were identified in two other locations in the designated centre during the walk around of the three houses. One shared bathroom located between two residents bedrooms had a door removed due to issues for one resident to access the area. However, no protocol was in place to ensure the privacy and dignity of the residents using the bathroom while awaiting the replacement door. The inspector was informed the door had been removed approximately two weeks prior to the inspection. Access to this area was possible through the two residents bedrooms, but staff were not ensuring the access from the other bedroom was limited when a resident was using the bathroom. Another resident was assessed to use a commode to support their toileting needs. However, this was observed to be located in their bedroom when not in use. This practice did not effectively support the resident's dignity.

The inspector was aware changes had been made to the layout of one to the houses during 2024 to support the assessed needs of one of the residents and reduce the safeguarding concerns that were present at that time. A self-contained apartment style area was created for the resident. This had been effective in supporting the resident to provide them with dedicated staffing supports and ensure the well being and safety of all residents. The change to the layout had reduced the size of the day room which residents from all three houses accessed. However, the impact was minimal and one resident who had complained about the changes at the time had been provided with an alternative space in their home which they decorated in-line with their preferences and choices. The inspector observed a clear glass panel was present on the bedroom door of the resident who was living in the apartment. This did not afford them privacy at night time and there was no rationale provided for the clear glass to be present. The inspector was informed this was an oversight and would be addressed and a replacement panel had been ordered during the inspection. The inspector acknowledges there was privacy glass on the entrance door to the apartment and windows that were facing out onto a courtyard where others may be passing.

The inspector observed a range of information available for residents pertaining to their rights in the houses. These included easy-to-understand leaflets, posters and details of who the designated officer and complaints officer was. There was information regarding assisted decision making and safeguarding. The provider was actively supporting residents to engage in activities which supported them to become more informed about their rights. This included attending advocacy meetings if they wished to do so. However, one resident informed the inspector they had been unable to attend a national conference in 2025 regarding advocacy. The inspector was informed by staff present that this was due to their health status at the time but the resident would be supported to attend the next event if they were well enough to attend. The resident confirmed to the inspector this was the reason for their non-attendance.

The inspector spoke with staff working in all three of the houses at different times of the day as well as the activity co-ordinator. All staff were familiar with the assessed

needs of the resident for whom they were providing support. Some staff had worked for many years in the designated centre and outlined the changing and increasing assessed needs of the residents. The recent admission of two new residents had also increased the demands on the staff but the addition of the activities co-ordinator was a welcome addition to the team. Staff spoke of the flexibility required to change plans to suit residents expressed wishes. There was access to multiple transport vehicles which was a positive resource to accessing community activities. Staff reported residents enjoyed participating in weekly dog therapy sessions and musicians also visited the designated centre frequently. Residents were supported to visit peers regularly in a nearby hub run by the provider. Arrangements with day services to collect and bring residents back to the designated centre helped the staff team support other residents.

In summary, residents were being supported by a dedicated core staff team. Staff spoken to were aware of previous safeguarding concerns and possible indicators of abuse. Residents were being provided with information in formats that suited their communication needs regarding advocacy, assisted decision making, human rights and safeguarding. However, further improvements were required by the provider to ensure all residents were consistently supported to have their privacy and dignity maintained with regards their personal environment and personal information. Repeat findings regarding the safe storage of food thickening agents also needed to be addressed. The risks associated with oxygen being used in one of the houses also required review.

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

Capacity and capability

Overall, this inspection found that residents were in receipt of good quality care and support provided by a consistent staff team. There were management systems in place to review if the residents received a good quality and safe service. The provider had taken actions to address findings from the previous Health Information and Quality Authority (HIQA) inspection in January 2024. However, there were two repeat findings on the day of this inspection which required further review to ensure consistency from the staff team regarding the secure storage of residents personal information and food thickening agents.

During the inspection, the inspector observed kind, caring and respectful interactions between the residents and staff. Residents were observed to appear comfortable and content in the presence of staff, and to seek them out for support as required. For example, when one resident became upset while talking to the inspector, the clinical nurse manager provided immediate re-assurance and outlined

how the team would support the resident regarding the issues they were talking about. This included re-arranging a visit with a relative to another day that suited both parties.

The focus of this inspection was on safeguarding practices in the centre in keeping with a programme of inspections started by the Chief Inspector during 2024. Overall, it was found that the monitoring practices for this centre did consider matters related to safeguarding. Staff spoken to demonstrated their knowledge around the types of abuse that can occur and relevant national standards. Staff also outlined protocols that were in place to provide specific support to residents in the designated centre. All staff working in the designated centre had attended relevant training and regular staff meetings were taking place.

Regular audits were taking place in the designated centre and actions identified were documented as being completed or in progress to ensure the ongoing safety of residents living in the designated centre.

Regulation 15: Staffing

The registered provider had ensured that the number, qualifications and skill mix of the staff team was appropriate to the number and assessed needs of the residents. Staffing resources were in-line with the statement of purpose. There was a consistent core group of staff, familiar to the residents working in the designated centre. There was evidence of ongoing review by the provider to ensure adequate staffing resources were available to support the assessed and changing needs of each resident. While there were no staff vacancies at the time of this inspection, the inspector was informed that additional funding for staff resources had been recently approved and a care assistant role was being recruited for.

The provider ensured a nurse was on duty at all times in the designated centre by day and night. Regular relief staff were available who were familiar to the residents, no agency staff were working in the designated centre. The provider had appointed an activities co-ordinator in January 2026 who worked Monday to Friday. In addition, there were staff allocated each day of the week as part of a day programme to support residents with activities and appointments. The commencement times of shifts were staggered to ensure staff resources were available at times that best suited the residents assessed needs. For example, one day shift was 10:00-22:00 hrs, this enabled residents to be supported with evening activities and provided additional support to the staff team when supporting residents with their night time routines.

There had been a change to the person in charge during 2025, a person participating in management who was familiar with the designated centre and the assessed needs of the residents was identified by the provider to take up the role while a new person in charge was recruited. This was in progress at the time of this inspection, the newly appointed staff member had commenced working in the designated centre and the required documentation was being prepared to be

submitted to the Chief Inspector of Social Services. The provider had systems in place that ensured ongoing oversight and two clinical nurse managers supported the person in charge during 2025 and remained in place at the time of this inspection as part of the local management team.

A selection of dates on actual and planned rosters since the 8 March 2026 until 25 April 2026, 7 weeks, were reviewed during the inspection. These reflected changes made due to unplanned events/leave and training. The minimum staffing levels and skill mix were found to have been consistently maintained both by day and night. However, the hours that were worked during the night time shift were not documented on the rotas or in a legend to inform the inspector of the start and end times of that shift. This was discussed during the feedback meeting at the end of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

At the time of this inspection the staff team was comprised of three clinical nurse managers, five nurses, a social care worker, 20 health care assistants and an administrative staff. There were also eight relief health care assistants available to support the staff team as required.

- The inspector reviewed a detailed training matrix which indicated that the staff team had completed a range of training courses to ensure they had the appropriate levels of knowledge, skills and competencies to best support residents while ensuring their safety and safeguarding them from all forms of abuse. These included on-line training in mandatory areas such as safeguarding.
- The clinical nurse manager provided updated information regarding the supervision that had taken place during 2025 with the staff team. The actual dates supervisions had taken place were unavailable for review during the inspection but were referenced in the provider's internal audit that they had been completed. Two clinical nurse managers had supported these supervisions during 2025. There was a planned schedule of supervisions for 2026 reviewed by the inspector. All staff including relief staff had supervisions scheduled for Quarter 1 2026. All relief staff and most of the core staff team had attended for their scheduled supervision. The inspector noted one core staff remained outstanding. The provider required staff to attend for supervision four times each year and these were scheduled in advance for 2026.
- The provider had identified incidents relating to medication errors had been occurring in the designated centre during an internal audit in July 2025. There were multiple causes which included errors occurring in the pharmacy. These had been addressed. Additional safety measures were put in place in the designated centre which included only nurses were to administer

medications during protected rounds and all health care assistants were trained in the safe administration of medications.
- Regular staff meetings were taking place monthly. The most recent meeting took place on 6 March 2026. The topic of safeguarding was discussed at the selection of staff meetings reviewed by the inspector. This included reminding staff about how to access safeguarding resources including training links, the process to follow in the event of an allegation of abuse and who the designated officer was.

Judgment: Compliant

Regulation 23: Governance and management

The provider was found to have governance and management systems in place to oversee and monitor the quality and safety of the care of residents in the centre.

- There was a management structure in place, with staff members reporting to the person in charge. Additional local management supports were in place with two clinical nurse managers working in the designated centre during 2025. An additional clinical nurse manager was recruited to the staff team during January 2026 and the inspector was informed this person had been recruited to become the person in charge of the designated centre. The required documented was been complied by the provider to submit to the Chief Inspector of Social Services at the time of this inspection.
- The person in charge was also supported in their role by senior managers within the organisation.
- The provider had ensured six monthly internal audits had been completed in the designated centre. Such audits had been completed in January 2026 and July 2025. The provider had a system to track actions identified in these audits to ensure progress. For example, there was ongoing review of staff training requirements within the designated centre. The person responsible to ensure actions were completed and updates were documented.

However, there was a repeat finding during this inspection. The provider had not ensured the personal information of residents was stored in a secure location as outlined in the statement of purpose. The inspector acknowledges that the provider had put locks on presses that were being used to store such information following the previous HIQA inspection in January 2024. During the walk around the inspector observed not all locks that were functioning as intended and there was an unlocked press in another house that was unattended by staff which did not ensure residents information was being consistently secured when not in use.

Judgment: Substantially compliant

Quality and safety

The purpose of this safeguarding inspection was to review the quality of service being afforded to residents and ensure they were being afforded a safe service which protected them from all forms of abuse, while promoting their human rights. However, further review was required to ensure the privacy and dignity of residents was being considered when using shared bathrooms, toileting equipment and the suitability of a bedroom door glass panel of the resident who lived in the apartment.

Residents were encouraged to build their confidence and independence, and to explore different activities and experiences. It was evident from observations made by the inspector and a review of documentation throughout the inspection, the staff team ensured residents were being supported to engage in various activities and had a routine that suited their assessed needs. The recent addition of an activities co-ordinator to the team assisted with increased opportunities and flexibility for residents to engage in activities both within the designated centre or in the wider community. Most residents were supported to engage in individual and group activities in-line with expressed wishes. One resident had progressed to attending swimming multiple times each week during 2025 but this had to be reviewed in recent weeks due to a known medical condition. At the time of this inspection, the resident was not engaging in many activities and staff were noticing a decline in their mobility. The inspector visited this resident's home on two occasions during the day, they were observed to be seated in the same seat looking out a window and listening to music on both occasions. Staff spoken with outlined the increased supports required by the resident to safely mobilise and engage in meaningful activities. This was being monitored by the staff team.

The inspector reviewed a number of documents including individualised personal plans for three of the residents, risk assessments and relevant safeguarding information. It was evidenced that there were systems in place where documents were subject to regular review, were reflective of the input of the resident and person centred. Individualised personal plans had been updated to reflect the residents current and changing supports needs. This included a range of support needs for each resident with detailed guidance to promote continuity of care. However, it had been identified in January 2026 that some goals for residents were too broad and required further review. While one of the resident's goals had been reviewed and updated with progress documented another had no further updates documented after the review that had taken place by a manager.

The premises had been subject to some upgrade and maintenance works since the previous inspection in January 2024. This included internal painting and the installation of an exit from the sitting room of one house to ensure ease of entry/exit for residents living there who required the use of mobility aids. Occupational therapists had reviewed the assessed needs of residents and recommendations had been implemented which included the re-positioning of toileting equipment in the bathrooms to facilitate staff to better support the

assessed needs of the residents. However, some internal maintenance was required. This included a curtain pole was observed to not be fitting correctly in a bedroom, an electrical junction box was missing a cover and some seating had damaged surfaces.

Regulation 10: Communication

The registered provider had ensured that each resident was assisted and supported to communicate in accordance with their assessed needs and wishes. This included verbal, easy-to-understand information and visual schedules.

- Residents had access to telephone, television and internet services in-line with their expressed wishes and assessed needs.
- Residents were supported to communicate with relatives, friends and peers in other designated centres.
- Each resident had an up-to-date communication passport to reflect their individuality and preferences when communicating with others. This included information relating to the preference of one resident to have a printed weekly visual schedule available to them at all times and developed in consultation with the resident each Sunday. This was observed to be in place during the inspection and used by the resident and staff team to discuss planned activities.
- Residents were provided with information in easy to understand format which included a resident guide, staying safe and advocacy.

Judgment: Compliant

Regulation 17: Premises

Overall, the centre was designed and laid out to meet the assessed needs of residents living in the designated centre. All three houses were visited during this inspection, all were observed to be well ventilated and decorated to reflect personal interests of the residents living there. This included photographs and music systems.

The actions from the previous HIQA inspection had been adequately addressed by the provider. Some additional internal maintenance had taken place which included painting, upgrading of kitchen presses and the installation of a self-contained apartment to support one resident. However, the inspector observed seating furniture in all three houses which appear tired and had damaged surfaces, a curtain pole was not securely fixed to the wall in a bedroom and the cover was missing from an electrical junction box in another bedroom.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had systems and processes in place for risk management at this centre. However, not all individual risks had been identified for a resident who required the use of oxygen 24 hours each day. While details of measures in place to reduce risk of harm to the resident and others while on the transport vehicle had been identified in April 2025 and subject to review since, there was no consideration given to the risk of having oxygen in the house. Also, there were no indicators to persons entering the house that oxygen was present. This was also required to be reviewed from the risk of potential fire. Regulation 28: Fire precautions was not reviewed during this focused inspection but was discussed during the feedback meeting.

In addition, while the inspector acknowledges that the provider had ensured locks had been placed on a press in each of the kitchens where food thickening agents were required to be used by residents after the previous HIQA inspection, not all locks were found to be in place on the day of the inspection. One house did have a locked press and staff were observed to be aware of and following the required protocol of locked storage of the product when not in use. This was not consistent with staff practices in another house. The inspector was informed the kitchen presses had been upgraded but the lock not replaced in that house. Staff spoken to seemed unaware of the requirement to ensure the product was to be stored in a locked press when not in use. One container of the product was on the kitchen counter as a staff member was preparing a drink for a resident. When checked the press in the kitchen contained additional containers of the product. The clinical nurse manager immediately requested staff to move the product to another location where it could be locked until the kitchen press could have a lock installed. This was a repeat finding for this designated centre and discussed during the feedback meeting at the end of the inspection.

The risk to two residents privacy and dignity when a door had to be removed on a shared bathroom approximately two weeks before the inspection while a replacement door was sourced had not been considered or temporary controls put in place to reduce the risk of adverse impact for either of the residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed different sections of three personal plans over the course of the inspection. Each resident had an assessment of need and personal plan in place. These plans were found to be well organised which clearly documented residents'

needs and abilities. There was evidence the residents had been consulted in the development of their personal plans. The language used was respectful and considerate of each resident. There were numerous photographs which showed residents enjoying a variety of activities.

However, not all residents personal goals were been updated or progressed. For example, no update was recorded for one resident since January 2026. It was unclear if they had commenced or completed any steps to progressing their goals at the time of this inspection. This included a goal to have an overnight break away with a peer. In addition, another resident had a goal to attend a social farm weekly but had only attended three times since the start of January 2026.

The inspector was informed another resident was choosing to not participate in many activities following a period of illness earlier in the year and an ongoing medical condition, While staff were aware of the changing assessed needs of the resident and were familiar with the resident's likes and dislikes, there was limited meaningful activities which the resident would engage in at the time of this inspection. The inspector was informed this had been high lighted also during a recent visit by members of The Irish Longitudinal Study on Aging (TILDA) project team to the designated centre.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were supported to experience the best possible mental health and to positively manage challenging issues. The provider ensured that residents had access to appointments with allied health care professionals such as, psychiatry and psychology.

- Two residents had behaviour support plans in place at the time of this inspection. Both plans had been reviewed during 2025 by the staff team and relevant allied healthcare professionals including the positive behaviour support team. Each plan had been developed in a person centred format, provided information about each resident and guidance of the supports each required. The plans had been updated when required. For example, staff were to ask one resident if there was anything they needed before they attended to others. This assisted with the resident's understanding of when staff would be able to support them. Staff were observed and overheard throughout the inspection to provide consistent responses in-line with this resident's behaviour support plan.

Judgment: Compliant

Regulation 8: Protection

All staff working in the designated centre had attended training in safeguarding of vulnerable adults, as per the details contained in the training matrix reviewed on the day of the inspection.

- The provider had ensured a policy for the protection and welfare of vulnerable adults was in place and subject to regular review. The current policy had been approved by the provider in July 2024.

- There were no open safeguarding plans in the designated centre at the time of this inspection. Actions taken by the provider in 2024 had been effective in reducing the risk of safeguarding concerns relating to specific incidents that had occurred.
- Each resident had personal and intimate care plans in place. These were subject to regular review and reflected if a resident could independently complete personal care or if assistance from staff was required. However, not all aspects of promoting resident's privacy and dignity when using shared bathrooms were documented. This will be actioned under Regulation 9: Residents rights.

Judgment: Compliant

Regulation 9: Residents' rights

The residents were supported to take part in the day-to-day decision making, such as morning routines, meal choices and to be aware of their rights through their meetings and discussions with staff. However, one resident was unable to attend their day service in-line with their expressed wishes. Due to a medical condition the resident required the use of oxygen and had been advised by the day service that they could not return to that building. The rationale was provided to the resident and staff team. The provider had sought to address the issue but were unsuccessful. The resident attends another day service one day each week, but this is not a decision the resident is happy with. The resident informed the inspector they wished to have the matter reviewed again.

While the staff team were striving to promote residents rights further improvements were required to be made to ensure consistent approaches were followed by all staff while ensuring the privacy and dignity of all residents.

- Not all residents privacy and dignity was ensured when using shared bathrooms or personal toileting equipment in the designated centre.
- One resident had a clear glass panel on their bedroom door which did not afford them privacy in their bedroom.

While the inspector acknowledges that the provider had installed locks on presses where residents personal information was being stored in communal areas since the previous HIQA inspection, not all locks were effectively working on the day of the inspection. This has been actioned under Regulation 23: Governance and management
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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for East Limerick Services OSV-0004779

Inspection ID: MON-0048092

Date of inspection: 09/04/2026

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • 10/04/26 following the inspection a meeting was held with the Maintenance dept. • 13/04/26 new locks were installed and are now functioning as intended outlined in the Statement of Purpose ensuring that the personal information of the residents is securely stored. • Staff meeting held on the 17/04/26 and 24/04/26 outlining the importance of securely storing the personal information of the residents. • The Clinical Nurse Managers will ensure through daily house visits that the personal information of the residents is stored appropriately. • The night roster has been updated to reflect shift times. • On review of the Support and Supervision records, the staff identified on the day of the inspection had received support and supervision on 12/03/26 as confirmed by the Person in Charge.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • 10/04/2026 following the inspection, a meeting was held with the Maintenance dept. • 10/04/2026 curtain pole was securely fixed to the wall in the resident's bedroom. • 13/04/26 privacy film installed on clear glass panel on resident's bedroom door. • 13/04/26 electrical cover on the junction box was replaced. • New chairs ordered in the designated center. Damaged chairs will be removed once	

delivered.
• 26/04/26 IPC audit completed in the designated center.
• Flooring in one house will be replaced by 30/06/26.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• 9/04/26 following the inspection the maintenance on call contacted. Door was reinstalled on the shared bathroom in one house in the designated center ensuring the privacy and dignity of two residents.
• 9/04/26 following the inspection Clinical Nurse Manager met with staff on duty in relation to the safe storage of thickening agent.
• 10/04/26 Risk assessment completed for the safe storage of thickening Agent.
• 14/04/26 meeting held with the Health and Safety Officer, Person in Charge and the Clinical Nurse Manager.
• 15/04/26 Oxygen signs installed in the designated center by the Health and Safety Officer.
• 10/04/26 lock installed on the kitchen press for the safe storage of thickener agent.
• 15/04/26 Risk Assessment completed with the Health and Safety Officer in relation to Oxygen storage.
• Staff meeting held on the 17/04/26 and 24/04/26 outlining the importance of the safe storage of thickening agent.
• Fire Brigade contacted and will visit the designated center to familiarise themselves with the storage of Oxygen. This will be completed by 31/05/26.

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:

• 13/04/26 Clinical Nurse Manager spoke to the keyworker regarding updating records for progressing personal goals.
• Staff booked in for Person Centered Planning (PCP) training.
• 13/04/26 Keyworker informed of documenting when resident chooses not to attend a planned activity and alternative offered. The will be reviewed as part of the individuals

weekly meeting.
• 19/04/26 Clinical Nurse Manager and keyworker completed a review of residents PCP goals and activity charts.
• Email sent to MDT members in relation to the review of residents PCP goals and updates.
• The Clinical Nurse Manager will discuss with the Keyworker during Support & Supervision the importance of maintaining and documenting information for the resident.
• Staff meeting held on the 17/04/26 and 24/04/26 outlining the importance of progressing PCP goals and meaningful activities.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• 9/04/26 following the inspection the maintenance on call contacted. Door was reinstalled on the shared bathroom in one house in the designated center ensuring the privacy and dignity of two residents.
• 13/04/26 privacy film installed on clear glass panel on resident's bedroom door.
• 10/04/26 personal toileting equipment now stored in the bathroom area to support the resident's dignity.
• 9/04/26 following the inspection maintenance on call contacted. Door was reinstalled on the shared bathroom in one house in the designated center ensuring the privacy and dignity of two residents.
• Intimate care plan updated in relation to the assessed toileting needs of the resident and their will and preference.
• 11/04/26 Clinical Nurse specialist (Behaviour Support Team) met with the resident regarding their day service. Clinical Nurse Specialist supported the resident to implement a plan to support the resident working through issues they find difficult.
• 14/04/26 meeting held with resident in relation to reviewing resident's day service in line with their expressed wishes.
• 14/04/26 the resident was advised in relation to her day service the opportunity to make a complaint through the Corlann Limerick's complaints procedure.
• PIC will explore possibility of increasing day services for resident within Corlann Limerick.
• 15/04/26 The Clinical Nurse Manager met with the management at the day service that the resident currently can't access. They confirmed the day center is not governed or insured for the use of Oxygen on their premises given that they are a voluntary agency. The resident has been informed of the outcome.
• 29/04/26 the resident had a meeting with the Psychologist to offer emotional and psychological support in relation to decisions about the residents care and offer her support in line with their expressed wishes.
• New individual day activity schedule will be completed weekly to promote activities that are more meaningful for the resident.

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 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.	Substantially Compliant	Yellow	30/06/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/06/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Not Compliant	Orange	31/05/2026

	ongoing review of risk, including a system for responding to emergencies.			
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 needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	24/04/2026
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	08/05/2026
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	Not Compliant	Orange	24/04/2026

	communications, relationships, intimate and personal care, professional consultations and personal information.			