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:	Waxwing 3
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	25 April 2025
Centre ID:	OSV-0006740
Fieldwork ID:	MON-0046598

About the designated centre

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

Waxwing 3 comprises a detached bungalow which can provide full time residential care for up to four adult men and women, with an intellectual disability. The house is located in a rural area on the outskirts of a small town in Co. Clare, with access to local shops and amenities in a nearby large city. The house comprises a kitchen, dining room and living room. All residents have their own bedrooms and there is also a shower room, bathroom and staff bedroom. There is a spacious garden to the rear of the property. Residents have access to transport and the service is provided through a social care model of support. All residents are supported to attend day services on weekdays as per their wishes. Residents are supported by a staff team of social care staff both during the day and at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Friday 25 April 2025	09:05hrs to 17:00hrs	Jackie Warren	Lead

What residents told us and what inspectors observed

This inspection was completed to assess the providers' compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with disabilities 2013 and, the National Standards for Adult Safeguarding (2019).

Based on the findings of this inspection, the inspector found that residents who lived in this centre had a good quality of life, had choices in most aspects of their daily lives, and were involved in activities that they enjoyed. The person in charge and staff were very focused on ensuring that a safe service was provided for residents, and that residents were well informed about recognising and responding to harm. However, improvement was required to the governance of the centre, and this impacted on the rights of residents. It was found that the financial management systems were restrictive. Some improvement to recording of risk management processes, personal planning, and use of restrictive interventions were also required.

Residents were not usually present in the centre during weekdays, as all residents attended external day service activities. However, the inspector got the opportunity to meet and speak with all three residents before they left the centre in the morning. These residents understood why the inspector was in the centre, and they were happy to talk about their experience of living there and on feeling safe. There was one staff present in the centre and it was clear during this time that there was a good rapport between residents, staff and the person in charge.

Residents told the inspector that they were very happy living there and enjoyed their daily lives. They said that they had good involvement in the community and talked about going out in the community for meals, outings to various activities and places of interest, meeting up socially with friends, visiting their families, and going for walks. They also enjoyed taking part in everyday community activities such as going the barber and hairdresser, carrying out recycling, attending medical appointments and shopping. Transport was available so that residents could go for leisure activities and attend local amenities. Residents also discussed safeguarding with the inspector. A resident explained what safeguarding meant. They gave examples of actions that would not be acceptable and said they would tell the staff if these happened to them. They said that staff had told them about staying safe, and it was clear from records in the centre that safeguarding information was being provided to residents. Residents also told the inspector that they all got on well and that they liked living together. All residents emphasised that they felt safe living in the centre.

The design and layout of the centre ensured that residents lived comfortably and had access to private space when required. The centre consisted of one large house, located in a rural area. A nearby village and city were accessible by car, which gave residents good access to a wide range of facilities and amenities. The centre was domestic style, spacious, and comfortably decorated. Each resident had their own

bedroom, and residents were happy to show the inspector their bedrooms which were comfortably furnished and decorated. All residents told the inspector that they liked the location of the centre and did not wish to live anywhere else.

Residents spoke to the inspector about how their rights were supported. They explained that they were registered to vote and could vote when they wanted to. They also talked about making food choices at weekly meetings in the centre, and that they liked to eat out at weekends. Residents had access to, and were involved in, advocacy services. The day before the inspection one resident had represented local services at a provider's regional advocacy meeting, while all three residents had attended a regional advocacy day earlier this year. Residents also discussed financial management; some were happy with the current arrangements, while some were not.

It was clear from observation in the centre, conversations with residents and staff, and information viewed during the inspection, that residents had a good quality of life, had choices in their daily lives, and were supported by staff to be involved in activities that they enjoyed, both in the centre and in the wider community. Throughout the inspection it was very clear that the person in charge and staff prioritised and supported the autonomy of residents and ensured that they were safe.

The next sections of this report present the inspection findings in relation to governance and management in the centre, and how it protected residents from harm and promoted their rights and quality of life.

Capacity and capability

The provider's management arrangements required strengthening to ensure that a good quality and safe service would continue to be provided for residents who lived in this centre. Although residents were receiving good care and had a good quality of life, improvement to the management oversight of the service was required. During this inspection several regulations relating to the protection of residents were found to be substantially compliant and required improvement. These included governance, staffing and staff recruitment, risk management, behaviour support and residents' rights.

Suitable arrangements were not in place for the management of the centre, including at times when the person in charge was absent. Overall, resources were in place to ensure that residents had meaningful lives and were protected from harm, although improvement to management resources were required. The resources in place included the provision of suitable, safe and comfortable accommodation and furnishing, transport, access to Wi-Fi, television, adequate staffing levels, and staff training relevant to residents' safety and welfare. However, the role of the person in charge was not adequately resourced to maintain effective governance and oversight in the centre.The person in charge had several other managerial duties

within the organisation and had not had the support of a team leader for some time. Although residents were found to have a good quality of life and were safe in the centre, the current management arrangements presented a risk that this standard of care might not be maintained. Furthermore, some essential managerial functions, including staff supervision and staff meetings, were not being completed in a timely manner, which gave rise to some regulations being substantially compliant. However, the person in charge stated that the provider had been involved in a recruitment process and that the team leader role was expected to be filled in the near future.

The organisational structure in place to manage the service was described in the statement of purpose. However, this structure was not in place at the time of inspection, which could impact on the effective oversight of the centre. While there was a management structure explained in the statement of purpose, the systems in place were not being carried out in line with this. Although, a person had been named to cover for the absence of person in charge, the identified arrangements did not come into effect when the person in charge was absent. Furthermore, staff in the centre were not aware of who had been nominated to cover for the absence of the person in charge. Ineffective cover for the management of the centre in the absence of the person in charge presented a risk to the safety and welfare of residents.

Adequate levels of suitably trained staff were being maintained in the centre to provide care in line with the assessed needs of residents, although improvement to the provider's recruitment process was required. Some of the information required by schedule 2 of the regulation had not been supplied for the inspector to view. It was, therefore, unclear as to whether or not this information had been gathered in respect of these staff. Staff who worked in the centre had attended training in various aspects of safeguarding and residents' rights, and there were relevant policies available to guide safeguarding and protection of residents.

Auditing of the service was being carried out in line with the provider's audit schedule. Unannounced audits of the service were carried out twice each year on behalf of the provider. These audits showed good levels of compliance and gave rise to action plans to address any issues identified. However, improvement was required to an aspect of the provider's unannounced audits. The action plan for the most recent audit did not state the person responsible for addressing the action, or the time frames for completion of actions.

The person in charge was aware of the requirement to make notifications of certain adverse incidents, including quarterly returns, to the Chief Inspector of Social Services within specified time frames. There was very low level of incidents that required to be notified within three days although any that had occurred, had been suitably submitted.

Regulation 15: Staffing

Adequate staffing levels were being maintained in the centre to provide care in line with the assessed needs of residents, although improvement to the provider's recruitment process was required.

At the time of inspection, there a vacancy for a social care workers whose role would be to support the person in charge in the everyday management of the centre. However, at the time of inspection this was at an advanced stage of being resolved. The provider had responded to this need by carrying out a recruitment process and the person in charge confirmed that this role was expected to be filled in the coming week. The inspector reviewed the staffing roster and found that sufficient staff were consistently being rostered to meet the wellbeing and safety needs of residents.

The provider failed to demonstrate that staff had been suitably recruited, and that the recruitment information specified in schedule 2 of the regulations had been obtained in respect of each staff member. Staff recruitment information was not available to view in the centre as it was kept in another office. The inspector requested to view the recruitment information required by schedule 2 of the regulations in respect of two staff, and this was supplied on the day. On review by the inspector, it was found that most of the required information was in place, including up-to-date vetting disclosures on both of the files viewed. However, some required information had not been supplied, namely full employment histories and details of previous experience. It was also not clear whether or not one staff reference had been verified. However, as there were up-to-date vetting disclosures in place on the files viewed, this did not present a safeguarding risk to residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had ensured that staff who worked in the centre had received training to support them to provide suitable care to residents and to ensure that residents were protected from harm. However, staff supervision meetings were not being carried out in line with the provider's systems.

The inspector viewed the staff training records which showed that staff who worked in the centre had received mandatory training in fire safety, behaviour support, and safeguarding, in addition to other training relevant to the safeguarding of residents, such as in childrens' first and assisted decision making. Code of practice training had commenced in the centre and many of the staff had attended this training. There were also a range of policies to guide staff in the protection of residents. These included up-to-date policies and procedures for adult safeguarding, provision of intimate care, provision of behaviour support and risk management. However the

communication policy had not been reviewed within the past three years as required by the regulations.

The person in charge acknowledged that, due to a deficit in management resources in the centre, staff supervision meetings were not being carried out.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvement to the provider's management arrangements and resources was required to ensure that a good quality and safe service would continue to be provided for residents who lived in this centre.

With regard to staffing and the role of the person in charge, the centre was not adequately resourced to maintain effective governance and oversight of the centre. Although residents were found to have a good quality of life and were safe in the centre, the current management arrangements presented a risk that this standard of care might not be maintained. The person in charge had several other managerial duties within the organisation in addition to the management of this centre. Traditionally they were supported in their role by a team leader, but this role had been vacant for some time and additional support had not been provided to the person in charge. Consequently, some essential managerial functions, were not being completed in a timely manner. For example, there was improvement required to documentation of risk management, restrictive practices and some personal planning information and these regulations were found to be substantially compliant. Furthermore, staff supervision and staff meetings were not being completed as required.

The organisational structure described to manage the service, including deputising arrangements for the person in charge, was not fully in place at the time of inspection, which could also impact on the effective oversight of the centre. Although there was a clear management structure explained in the statement of purpose, the systems in place were not being carried out in line with this. Suitable arrangements were not in place for the management of the centre, including at times when the person in charge was absent. Prior to carrying out this inspection, the inspector called to the centre on two occasions to carry out this unannounced inspection, but on both occasions the person in charge was not available. On these occasions the deputising arrangements did not come into effect and the inspections had to be abandoned. Furthermore, a staff member who spoke with the inspector was not aware of who had been nominated to cover for the absence of the person in charge. Ineffective cover for the management of the centre in the absence of the person in charge presented a risk to the safety and welfare of residents.

Staff recruitment in the centre also required improvement. The inspector reviewed the recruitment files of two staff and found that both files did not contain some of the information required by schedule 2 of the regulations.

Some improvement was required to the provider's auditing process. Auditing of the service was being carried out in line with the provider's audit schedule. Unannounced audits of the service were carried out twice each year on behalf of the provider. However, in the most recent unannounced audit, the person responsible for addressing the required areas for improvement, and the time frames for completion of actions, were not identified. As there was no target, this presented a risk that these actions may not completed in a realistic and timely manner.

Judgment: Not compliant

Quality and safety

Based on the findings of this inspection, there was a good level of compliance with regulations relating to how residents who lived in the centre were protected from any form of harm. The person in charge and staff in this service were very focused on ensuring that residents had information about being safe, were supported to communicate effectively, had comfortable and safe living environment, and were aware of their rights. However, improvement was required to aspects of personal planning, risk management, recording of restrictive practice and management of residents' finances.

The centre was made up of one house, which could accommodate up to three residents. The centre suited the needs of the residents, was of sound construction and well maintained, was clean, safe and was suitably decorated and equipped throughout. During a walk around the centre, the inspector found that the house was clean, comfortable and nicely furnished. There was adequate furniture such as wardrobes, bedside lockers and chests of drawers in which residents could store their clothing and belongings in their bedrooms. There was a well-maintained enclosed garden behind the centre. The centre was also equipped with Wi-Fi and televisions for residents' use.

The provider had arrangements in place to safeguard residents from any form of harm. These included safeguarding processes, identification and management of risks in the centre, including individualised risks, and processes to support resident to manage behaviours of concern as required. Overall, there were good procedures in place to manage risk and keep residents safe in the centre. However, the recording of individualised risks required improvement. Although there was limited use of restrictive practice in the centre, the provider's systems restricted residents' access to their own money and to banking choices. This impacted on residents'

freedom to exercise choice and control in their daily lives in respect of access to, and use of, their money.

Residents had access to information, including information about their rights and about keeping safe.The provider had ensured that residents were supported and assisted to communicate in accordance with their needs and wishes, and that they had been provided with information about protection and staying safe. Information was also made available to residents in user friendly formats to increase their awareness and understanding of safeguarding. Residents had access to both complaints and advocacy processes, they were aware of their rights, they knew how to raise any complaint or concern, and they told the inspector that they would raise any issues of concern with staff.

Assessments of health, personal and social care needs were in place for each resident. Individualised personal plans had been developed for residents based on their assessed needs, and meaningful personal goals had been agreed with each resident. Plans of care had been developed to guide staff on the appropriate and safe management of residents' healthcare, safeguarding, and social and developmental needs. Where required, personal planning information included positive behaviour support guidance to ensure that staff had the information to support residents appropriately. However, the annual review of one resident's personal plan was overdue.

Regulation 10: Communication

The provider had ensured that residents were supported and assisted to communicate in accordance with their needs and wishes, and that they had been provided with information about protection and staying safe.

The person in charge and staff were very focused on ensuring that they communicated appropriately with residents. When residents were present in the centre before going out to their planned activities in the morning, the inspector saw staff communicating with residents in line with their capacity. This was mainly through verbal communication as this suited the needs of the residents who were present. However, the inspector saw that there were other communication systems in place to support a resident who required additional support, and these included an up-to-date communication plan, a visual shopping basket, a talk application for the resident's computerised tablet and the involvement of a speech and language therapist.

To support the comprehension and understanding of all residents, a range of easy read information documents had been developed and made available to them. The information that related to keeping residents safe, included handling of personal assets, communication, education and training, confidentiality, restrictions, intimate care and missing persons. Residents met together for a house meeting every week. The inspector read the minutes of three house meeting and found that complaints, concerns, dignity and respect, and safeguarding had been discussed at these

meetings. On speaking with residents, the inspector found that they had a good understanding of safeguarding and were clear about what they would do if they felt unsafe.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre met the aims and objectives of the service, was safe, and met the assessed needs of residents. The centre comprised one house in a housing estate in a rural area. There were no issued identified in the centre which would would impact negatively on the safety of residents. Transport was available at the centre for residents to access the facilities of the neighbouring village and city. Residents told the inspector that they were happy with this and liked the location of the centre. During a walk around the centre, the inspector saw that all parts were well maintained, clean, comfortably decorated and safe. All residents had their own bedrooms, which were personalised to their liking. There were gardens to the front and rear of the centre, including a secure garden behind the house. Specialised equipment was not required to meet residents assessed mobility needs. The centre was served by an external refuse collection service and there were laundry facilities for residents to use.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had procedures in place to manage risk and keep residents safe in the centre. However, the recording of individualised risks required improvement.

The inspector viewed the the provider's risk management arrangements which ensure ensured that risks were identified, monitored and regularly reviewed. The inspector viewed the risk register and found that it identified a range of risks associated with the service and documented interventions to reduce these risks. The inspector saw that further individualised risk assessments had been carried out to identify and manage risks specific to each resident. However, some of the individualised risk assessments were not filed on residents' files but were recorded on a computer system that staff did not have access to. Although a staff member who spoke with the the inspector was very knowledgeable of residents' needs, the absence of accessible risk assessment information, presented a risk that all required

risk management intervention and information may not be available to inform all staff. There was a risk management policy to guide practice.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal plans had been developed for all residents and were based on each resident's assessed needs. Residents' personal goals were agreed at these meetings. However, one resident's personal plan was out-to-date and required review.

Comprehensive assessment of the health, personal and social care needs of residents had been carried out and, individualised personal care plans had been developed for each resident based on their assessed needs. The inspector viewed a sample of two residents' personal plans and found that these had been developed with input from the provider's multidisciplinary team, and these plans had been made available to residents in easy read formats that suited their needs. Part of the personal planning process included assessments to ensure residents' knowledge rights to wellbeing and safety. For example, the inspector saw that assessments of residents' understanding of fire safety, protection, and the complaints process had been carried out. Personal goals had been developed for each resident. Staff who spoke with the inspector were very familiar and knowledgeable about residents' personal plans and how achievement of their goals was progressing. Examples of some of the meaningful goals that residents were working towards included, going for holidays, attending an advocacy course, developing household skills, taking part in sporting events and healthy eating. One resident's person plan had not been updated annually as required by the regulations and the provider's procedure as set out in the statement of purpose. This plan had not been reviewed since late in 2023. This presented a risk that the most up-to-date information about the resident's wishes and choices might not be available to guide staff.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Use of financial restrictive practices in the centre were not being managed in line with the national policy and evidence based practice. The provider's systems restricted residents' access to their own money and to banking choices.

The inspector's review of the policy and discussions with staff showed that the processes in place for the management of residents' money were restrictive, and limited residents' choices around access to their money, and banking choices. However, this was not being recognised as a restrictive practice by the provider, was

not recorded in the centre's restrictive practice records, and had not been submitted as a restrictive practice in the provider's notifications to the Chief Inspector of Social Services. Furthermore, there was no evidence that any less restrictive financial practices had been considered or that these practices were the least restrictive options.

The provider had procedures in place to ensure that behaviours of concern were appropriately managed to keep residents safe. Overall there was limited behaviours of concern in the centre, although some restrictions were in place to safeguard residents from harm. Restrictions included, for example, restricted access to certain food items, sharp implements, and cigarettes, and locking of doors and outdoor gates daily. The inspector was told that these were in place to support a resident for health and safety reasons. However, there was no record that these continued to be the least restrictive options. Furthermore, although these actions were also impacting on other residents, this was not acknowledged in mandatory notifications to the Chief Inspector.

There were up-to-date policies on management of behaviours of concern and use of restrictive practices, and multidisciplinary support was available to residents.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had arrangements in place to safeguard residents from harm. These included development of intimate care plans and missing person profiles for each resident, and access to a safeguarding process. Information was also made available to residents in user friendly formats to increase their awareness and understanding of safeguarding. Residents who spoke with the inspector were aware of being safe and what this meant to them. The said that if they did not feel safe or if anyone hurt them, that they would tell a staff member or the person in charge. They said that they trusted staff.

Judgment: Compliant

Regulation 9: Residents' rights

Residents did not have freedom to exercise choice and control in their daily lives with regard to the management of their finances. Although there were systems in place to support residents' human rights, improvement to financial management was required, as the provider's systems restricted some residents access to their own money, spending, and to banking choices. The inspector's review of the policy and discussions with staff showed that residents required consent from the person in

charge to make purchases over a certain amount, residents were restricted to using one specific bank and did not have the option to use other banking options such as credit unions or mobile finance applications. Furthermore due to the structure of the accounts in place for most residents, they did not have any access to online shopping or online banking.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Waxwing 3 OSV-0006740

Inspection ID: MON-0046598

Date of inspection: 25/04/2025

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:

• Social Care Leader - Vacancy
○ The Vacancy for the Social Care Leader/ Team Leader was filled on 27/04/2025

• Schedule 2 Recruitment information
○ Both staff files which were shared with the inspector on the day were reviewed by the Human Resources department. It was confirmed that all pre-employment checks including their CV (which holds previous experience and employment history) are on file.
○ There are 2 statements of employment on file for one staff file which were accepted as references by HR. 10/06/2025. The 2 organization where this person worked had a policy of not providing references.
○ The HR department confirmed that all Schedule 2 information is in place for all staff prior to their onboarding.</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development

• Staff Supervision
○ Social Care Leader/ Team leader in place since 27/04/2025. This is a supernumery position to support the PIC role.
○ Staff supervision for Q2 2025, for all staff in the center scheduled to be completed by 30/06/2025.
○ Quarterly supervisions will be scheduled by the Team Leader thereafter.
○ PIC has regular supervision with the newly appointed Team Leader (weekly) with formal support and supervision on a quarterly basis.</td></tr>
</table>

- Staff meetings
  - Monthly staff meetings to commence for the centre, first one to be completed by 30/06/2025.
  - Monthly meetings to be scheduled thereafter by the team leader.
  - Periodically the PIC will attend these meetings to support the team leader and staff team.

- Communications policy
  - NPAG (national policy action group) of the Brothers of Charity Service Ireland has completed a review of this policy which was forwarded to the National Chief Executive for sign off on 05/06/2025.
  - This revised policy will be circulated no later than 31/08/2025

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- Social Care Leader Vacancy
  - The Vacancy for the Social Care Leader/ Team Leader post was filled on 27/04/2025

- Risk Management procedures
  - Review of risk management procedures in the centre to be completed by the team leader by 30/06/2025
  - A risk log will be updated and a hard copy will be available in each residents file 30/06/2025
  - A full copy of all reviewed risks in the centre will be available in hard copy in the risk register, 30/06/2025

- Restrictive practices
  - Review of restrictive practices in the centre for Q2 2025 will be completed by the team leader in 30/06/2025
  - A comprehensive review including PIC and Clinical Team of all restrictive practices in the centre will be completed by 30/09/2025.

- Personal Planning
  - The person whose PCP was outstanding as noted in the report completed her planning meeting on 10th June 2025.
  - All PCPs are in place for all persons supported since 10/06/2025

- Staff Supervision
  - Social Care Leader/ Team leader in place since 27/04/2025. This is a supernumery position to support the PIC role.
  - Staff supervision for Q2 2025, for all staff in the center scheduled to be completed by 30/06/2025.

- Quarterly supervisions will be scheduled by the Team Leader thereafter.
- PIC has regular supervision with the newly appointed Team Leader (weekly) with formal support and supervision on a quarterly basis.

- Staff meetings
  - Monthly staff meetings to commence for the centre, first one to be completed by 30/06/2025.
  - Monthly meetings to be scheduled thereafter by the team leader.
  - PIC has have regular supervision with the newly appointed Team Leader (weekly) with formal support and supervision on a quarterly basis.

- Deputizing arrangements for the person in charge
  - The SOP sets out the organization management structure for the Services.
  - At the time of inspection the post of full time team leader whose role is to work full time and supernumery in the designated centre was vacant. This represented a gap in the governance structure of the centre.
  - At the time of the inspection this post was actively been recruit for and an offer made to the successful candidate.
  - This team leader commenced in their role on 27th April 2025, providing governance and management to the centre, with the support of the PIC & named person. Therefore from this date the BOCSILR are satisfied that suitable deputising arrangements are in place for the designated centre.

- Schedule 2 Recruitment information
  - Both staff files which were shared with the inspector on the day were reviewed by the Human Resources department. It was confirmed that all pre-employment checks including their CV (which holds previous experience and employment history) are on file.
  - There are 2 statements of employment on file for one staff file which were accepted as references by HR. 10/06/2025. The 2 organization where this person worked had a policy of not providing references.
  - The HR department confirmed that all Schedule 2 information is in place for all staff prior to their onboarding.

- Unannounced audits
  - On receipt of a 6 month review report there is an expectation that the PIC reviews the report with their manager and that responsibility for actions as well as timelines are agreed and recording on the report.
  - All persons in charge were reminded of this requirement at the provider / person in charge meeting on 28/05/2025.

Regulation 26: Risk management procedures	Substantially Compliant

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

- Risk Management procedures

- Review of risk management procedures in the centre to be completed by the team leader by 30/06/2025
- A risk log will be updated and a hard copy will be available in each residents file 30/06/2025
- A full copy of all reviewed risks in the centre will be available in hard copy in the risk register, 30/06/2025

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:

- Individual assessment and personal plan
  - The person whose PCP was outstanding as noted in the report completed her planning meeting on 10th June 2025.
  - All PCPs are in place for all persons supported since 10/06/2025

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- The following are the supports in place to support residents to manage their personal assets.
  - The BOCSILR had identified the Person in Care account, developed by one financial institution, as the appropriate bank account to offer people supported who require support of staff employed by the BOCSILR in the management of their money. This account offers safeguards to both staff in accessing another person's bank account and also allows for safeguards to the person supported in protecting their money. The service recognizes that this account is inherently restrictive. The Personal Assets policy addresses this in that it sets out the nature of the support that the BOCSILR can offer to persons supported and gives individuals the choice to opt in or opt out of this support.
  - 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 (Person in Care Account) through which support can be offered in a safe manner both for the person supported and for staff. While this account does not allow for online purchases, alternative arrangements are available to facilitate these purchases, if a person requires this.
- 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 supported 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. There has been no success to date. We will continue to pursue.
- We understand there are different policies relating to personal assets operating within the BOCSI. BOCSILR will seek to place this matter on the agenda for national discussions.

Restrictive practices

- Review of restrictive practices in the centre for Q2 2025 will be completed by the team leader in 30/06/2025
- A comprehensive review including PIC and Clinical Team of all restrictive practices in the centre will be completed by 30/09/2025.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

- Residents' rights
  - As stated under regulation 7 residents’ have the right to opt in or out of support from the BOCSILR to manage their personal assets. This is clearly set out in the permissions form which is part of the personal assets policy.
  - Internet banking is not available as this is a stipulation of the person in care account.
  - While it is possible for online purchases to be completed using the debit card attached to a person-in-care account the majority of online retailers

now have 'two-factor authentication' in place which require verification via internet banking. This facility is not currently available on accounts with person in care features. While this account does not allow for online purchases, alternative arrangements are available to facilitate these purchases, if a person requires this.

- The above limitations to accounts with person in care features are clearly set out in the policy to support people to make an informed decision when opting in or out of support from the BOCSILR in the management of their personal assets.
- 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 and also provide a safe arrangement for staff to support people with their finances.
- While there are protections in place to ensure their money is safeguarded there are no restrictions on what a person can spend their money on, other than the funds they have available to them in their account.
- As a result of the recent ADMA legislation the Person in Care account has been withdrawn by the financial institution and the BOCSILR are actively engaging with other institutions to find an alternative and suitable account. This institution who has withdrawn the Person in care account is recommending consideration of the use of the HSE's patient private property account which the BOCSILR deems to further restrictive. The BOCSILR has written directly to the Decision Support Service setting out our concerns regarding the current banking services available to people who require support with their finances as a result of the ADMA legislation.
- An interim arrangement is in place of one person supported in the centre who does not have a person in care account and cannot be supported by staff of the BOCSILR via his traditional deposit and current account, until such time as an alternative and appropriate bank account can be arranged.
- Following this inspection this person supported will be referred by the BOCSILR to access an independent advocate to assist him in this matter.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	27/04/2025
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	10/06/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/06/2025
Regulation 23(1)(a)	The registered provider shall	Substantially Compliant	Yellow	27/04/2025

	ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	27/04/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/07/2025

Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	30/06/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/06/2025
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Substantially Compliant	Yellow	13/06/2025

Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/06/2025
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	31/12/2026