Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Le Cheile
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	18 October 2023
Centre ID:	OSV-0004752
Fieldwork ID:	MON-0041310

About the designated centre

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

Le Cheile consists of two large one-storey detached houses located on a campus setting on the outskirts of a city. The centre is currently under renovation with one house unoccupied to allow for complete renovation. This house when complete will support the assessed needs of six residents. One house which provides support for six residents has been renovated to ensure the environment was suitable to the assessed needs of residents. The centre can provide full-time residential care for residents over the age of 18 of both genders with intellectual disabilities. Each resident in the centre has their own bedroom and other facilities throughout the centre include dining rooms, living rooms, kitchens and bathrooms amongst others. Residents are supported by nursing staff and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 18 October 2023	09:00hrs to 17:00hrs	Laura O'Sullivan	Lead
Wednesday 18 October 2023	09:00hrs to 17:00hrs	Louise O'Sullivan	Lead

What residents told us and what inspectors observed

This was a short term announced inspection completed in designated centre Le Cheile. The centre consists of two areas based on a large campus setting. The inspection was completed as part of an inspection of centres based on the Bawnmore campus. This was facilitated by residents, staff and members of the governance team. Currently in this centre one house is the process of undergoing renovations to allow residents to transition to a home specific to their assessed needs. This is part of a wider plan in place by the provider.

The inspectors had the opportunity to visit the house of the centre currently in operation. This house has been renovated and decorated to meet the individual needs of the residents. The centre was warm and homely with aromatherapy oils used to promote a calm environment. The premises allowed residents ample communal space to interact with peers or to spend time in their bedrooms. One resident had recently transitioned to the centre and staff were actively supporting them to decorate their personal space in accordance with their individual interests and preferences.

The residents in the centre were observed to participate in activation on the day of the inspection. One resident was supported by staff to attend a local pet farm to see the animals. This was activity they enjoyed. Other residents were observed partaking in a sensory baking session and seen to enjoy the finished cakes. Each resident had a photo album which was used to show participation of their favourite activities and their personal goals. This included overnight trips away, concerts and shopping.

Through the use of visual schedules and accessible information residents were supported to choose which activity they favoured. A visual timetable was in place for daily house activities and for activities available within the onsite day service. Residents currently residing in the centre communicated through non-verbal methods such as facial expression and vocalisations. Staff were observed interacting with residents in accordance with their communication needs. Residents smiled at staff when spoken with and appeared very comfortable in their company.

The inspectors observed that staff had a keen awareness of the support needs of residents, including their health c and social care needs. They spoke very clearly of the residents' right to dignity and respect in all areas of their life including choice of activities, medical interventions and living arrangements. This inspection found that there was a good level of compliance with the regulations concerning the care and support of residents and that this meant that residents were being afforded safe and person-centred services that met their assessed needs, notwithstanding the ongoing work to premises. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the

service being delivered.

Capacity and capability

Bawnmore campus is made up of five centres, with each centre having an additional condition, for this designated centre Le Cheile the additional condition is: "The provider shall address the regulatory non compliance as outlined in the plan dated 21 September 2020 to the satisfaction of the Office of the Chief Inspector no later than 14 March 2024. This condition is pertaining to fire and premises. Premises and fire precautions continued to be not complaint on this inspection, however the provider had assessments in place to mitigate the risk and are actively addressing this within this centre with one house compliant and another in the final stages of renovations. The campus was inspected over a two day period with each centre been inspected as per the Health act 2007 and the regulations. It was also evident that there was an increased focus on the lived experience for residents despite the current environmental constraints

There was a specific emphasis on this inspection in relation to the lived experience and quality of life for residents given their current living environment. The providers overall plan for the campus related to a high level decongregation plan for Bawnmore with details pertaining to each individual centre. On the day of inspection the provider gave an update in relation to the project plan and also gave the inspectors a detailed plan of progress to date. It was evident that the provider was keeping as much as possible to these time lines and demonstrated oversight and commitment to this project plan.

The provider has very good systems in place for the oversight and monitoring of the centre there was evidence of monthly meetings with senior managers, meetings with persons in charge, clinical nurse managers and staff meetings. The agenda items discussed areas such as, complaints, safeguarding, recruitment, best practice, quality and operations items and it was also seen that areas such as TILDA, dementia care, changing needs and planning with the acute setting was discussed so as to enhance the quality of care and support delivered by the provider.

The provider had good oversight in relation to audits and reviews. It was seen on the day of inspection that all safeguarding measures were implemented and that the person in charge on a monthly basis reviewed all incidents and ensured there was follow up where required.

The registered provider had ensured the staff team allocated to this centre were supported to receive the required training to meet the assessed needs of residents. There was also good evidence of staff supervisions and documented evidence that staff could raise concerns if required. It was noted from the documentation and from speaking with persons in charge that a learning review took place post

inspections and that the team of persons' in charge worked together to ensure consistency across the five centres on the Bawnmore campus.

The provider was afforded time to revert back to the chief inspector with an updated statement of purpose to incorporate the night time arrangements, both from a staffing and accountability perspective, they were also afforded the time to review the floor plans of the centre as these plans form part of the conditions of registration.

The provider did demonstrate that they are seeking advice in relation to consent issues due to the assisted decision making act 2015 as they wanted to ensure they were supporting the rights of residents. They were awaiting further legal advice on same. The inspectors did not review the contracts of care as they afforded the provider the opportunity to follow this up so the rights of residents was not compromised. It was noted that residents had bank accounts with the one banking organisation and that bank statements were to the providers business address. Clarity was sough in relation to the resident's choice of banking and if consent was given and if residents were afforded a preference of whom to bank with. The provider did not have any evidence to support that the residents were involved to select a bank of their choosing, were consulted and had the freedom to exercise control in relation to this. This will be discussed further under residents rights.

Registration Regulation 5: Application for registration or renewal of registration

The provider had ensured an application to renew the registration had been submitted as per regulatory requirements. However, the provider had been requested to review all of the floor plans to ensure they accurately reflected the actual layout of each room in the designated centre as per Schedule 1 of the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre. They were full time in their role and held governance over one designated centre.

The person in charge had a keen awareness to the assessed needs of the residents in the centre and of their regulatory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had appointed a staff team to the centre. There was an actual and planned roster in place which evidenced continuity of care was being afforded to residents through the core staff team. The provider had assessed that nursing care was provided to residents at all times. During night-time hours one staff was allocated to support residents within Le Cheile. Residents within the centre required two staff to provide supports in such areas as personal care and manual handling. While staff spoke of the measures for this support to be provided there was no protocol in place for review or evidence that this was provided promptly.

This arrangement was not accurately reflected within the actual and planned roster. It was also not documented within the statement of purpose of the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had effective systems in place for the appropriate supervision of the staff team. This included formal supervisory meetings in accordance with the organisational policy. Staff were also supported to attend regular house meetings to discuss any concerns or issues within the centre.

The person in charge had effective measures in place to ensure the staff team were supported and facilitated to access training. A training matrix was in place which monitored staff training needs with this booked in advance. Training afforded to staff was reflective of the assessed needs of residents and incorporated such areas as human rights, manual handling and safeguarding vulnerable adults from abuse. If required specific training was facilitated to support individual residents, for example dementia care.

Judgment: Compliant

Regulation 21: Records

Improvements were required in relation to records; Regulation 21. A sample of staff files were reviewed for staff employed the provider had records in place as per schedule 2. However there was not a clear process for people working in the centre who were on a community employment scheme CE. The only supporting

documentation was Garda Vetting and a training record. The statement of purpose included CE workers as part of the staffing compliment within the statement of purpose and they carried out the same functions as some of the staff. There was no list of duties, no evidence of an induction and no evidence of the records as per schedule 2. On the day of inspection the provider agreed to ensure that the same process would be in place as for staff employed by the provider.

Judgment: Substantially compliant

Regulation 23: Governance and management

It was evidenced throughout the inspection that there was effective oversight in the day to day operations of the centre. Through the use of a range of monitoring systems actions were implemented to address areas of non-compliance in a prompt manner. This included the annual review of service provision and six monthly unannounced visits to the centre. There was evidence of clear communication within the governance structure with clear roles and responsibilities in place.

Le Cheile has an additional condition of registration in place that the provider shall address the regulatory noncompliances as outlined in the plan dated 21 September 2020 to the satisfaction of the Chief Inspector no later than 14 March 2024. The provider has had delays in meeting this condition and there has been extensive regulatory engagement between HIQA and the provider since 2021. While over the provider had significant delays in the overall progress with the fire safety plan, work was in progress to ensure the condition was adhered to by March 2024. One house was fire complaint and renovated, with the second houses in the final stages of renovation.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had ensure the development and review of the Statement of purpose. The provider had been afforded time to ensure this accurately reflected the function of the centre. This included the staffing arrangements at night and the use of CE scheme staff.

The provider was afforded time to complete this action.

Judgment: Compliant

Quality and safety

As stated previously this was a short term announced inspection completed within designated centre Le Cheile. The centre currently operated one house with provided full time supports to six resident who presented with multiple and complex support needs. Another house which will be in a position to support six residents was currently under renovations to ensure this area was fire compliant and the layout was suitable to the assessed needs of intended residents.

The provider was supporting residents to actively decorate their current living arrangements in accordance with their individual interests, tastes and hobbies. Some residents displayed family photos or certificates they have received over the years. The house which was currently operational under the remit of the centre was tastefully decorated and used the layout of the building to support the individual needs of residents. For example, one resident had an area in the living room where they enjoyed getting a break from their wheelchair in a comfortable and sensory space. Storage of medicinal products in the centre was completed in a manner which maintained the home like environment of the space.

The person in charge had ensured each resident had comprehensive individualised personal plans. These plans incorporated the annual review of each residents assessed needs. These reviews incorporated recommendations from relevant members of the multi-disciplinary team including speech and language therapists, physiotherapist etc. Personal plans incorporated holistic approach to support needs including health care plans, mental health and communication. These were regulatory reviewed by the allocated keyworkers to ensure the plans reflected the current assessed needs of residents.

Each resident was supported through a person centred planning approach each resident was supported to develop person goals. While progression of these goals were documented within the personal plan these were further enhanced through the use of photo albums. Staff spoke of residents and families enjoyed looking at photographs of participation in activities. The residents in the centre were observed engaging in meaningful activities through the inspection. This included group activities in the hub located within the campus, in house activities of their choice such as sensory baking, or engaging in social activities in the local community. The centre had access to a vehicle to support this community inclusion.

Each resident was supported in the administration of medication as prescribed. Where a resident was prescribed medication as required improvements were required to ensure this medication were within the best before date. While the area of medications was regularly audited this required review to ensure all practices were completed to ensure adherence to organisational policy and best practice. There was no clear system in place to monitor the expiry date of stock within the centre.

The registered provider had ensured the designated centre was operated in a

manner which promoted the safety of residents. Residents' rights were promoted also through communication and consultation with residents. Accessible information was used within person centred planning meetings and weekly residents meetings to encourage participation and promote understanding of topics discussed. Staff spoken with had a clear understanding of how to support residents' rights and how to ensure this right was maintained at all times.

Some residents had bank accounts with one organisation and as stated previously the statements of which were post to the providers business address and not to the individual. There was also not clear evidence that all residents had been presented with sufficient information to consent to this process. Where residents required additional support to access to their personal finances outside of this policy the person in charge was supporting them with this process.

Regulation 13: General welfare and development

It was evidenced over the course of the inspection that residents in the centre were supported to live an active and meaningful life. Relationships in the wider community were facilitated.Residents were offered choices with respect to activities, be it in house, the onsite day service or in the local community.

Judgment: Compliant

Regulation 17: Premises

The provider had made efforts to ensure the environment was homelike and residents were afforded the opportunity to decorate their personal space with items of interest such as art work, family photos and decorations. While one area of the centre had been renovated to a high standard and the layout was suitable to the assessed needs of residents; one house under the remit of the centre was currently under renovation and at the time of the inspection was not complete.

Judgment: Substantially compliant

Regulation 28: Fire precautions

One area of the centre had been evidenced to be fire compliant. As stated previously the second house under the remit of the centre was currently under renovation with a plan in place to ensure fire compliance was in place with effective

fire management systems in place.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Overall, there were effective systems in place in the area of medicinal products. Each area under the remit of the centre had a secure location for the storage of medicinal products. Medications to be administered were clearly documented on kardex which were signed and review by GP as per the organisational policy. Quarterly audits were completed to ensure adherence to best practice.

However, some improvements were required. For example, some medicinal products were identified to be out of date. No systems was in place to monitor this as set out in the organisational policy.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that each resident had an individualised comprehensive personal plan. These were evidenced to be multi-disciplinary in nature and incorporated a holistic approach to support needs. This included, health care, social and psychological support needs. All plans were reviewed on a regular basis to ensure they reflected the individual's current assessed needs.

Each resident had been supported to develop personal goals. There was evidence of progression and participation of these goals.

Judgment: Compliant

Regulation 8: Protection

The registered provider had implemented a number of measures to ensure all residents were protected from abuse. This included staff training, the ongoing comprehensive review of incidents and adherence to safeguarding plans. Staff spoken with were knowledgeable to the process to adhere to should a safeguarding concern arise. This included the pathway of reporting and ensuring the well-being of the individual.

Residents were provided with information about safeguarding and abuse in an

accessible format. Residents reported feeling safe in the centre and being aware of who they could speak with. Safeguarding and keeping safe was a regular topic discussed as part of resident meetings.

Residents had imitate care plans and personal care plans in place, which detailed the supports required in this area including favoured staff supports and level of prompting required to complete tasks independently.

Judgment: Compliant

Regulation 9: Residents' rights

The centre was operated in a manner which was respectful to the residents and their assessed needs. Residents were consulted in the day to day running of the centre and encouraged to voice their concerns and opinions. Communication with residents was evident and they were included in decisions with respect to their daily life. This included in such areas as safeguarding and restrictive practice.

Some residents had bank accounts with the one banking organisation and residents' bank statements went to the providers business address. The provider did not have any evidence to support that the residents were involved to select a bank of their choosing, were consulted and had the freedom to exercise control in relation to this.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Le Cheile OSV-0004752

Inspection ID: MON-0041310

Date of inspection: 18/10/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Protocol for assistance with People and Manual Handling put in place by the Night Managers on the 24-10-2023. • Statement of Purpose updated to reflect the management system in place by night in relation to the manual handling requirements of residents. • Statement of Purpose resubmitted to HIQA on the 07-11-2023.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • Meeting arranged for the 30/11/2023 with the Assistant Director of Nursing, Human Resources and the supervisor of the sponsor organisation for the Community Employment scheme to progress a clear process for people working in the designated centre who are on the Community Employment scheme. • The sponsor organisation will provide the BOCSILR Human Resources dept. with a CV and references for each of the participants of the community Employment scheme. • The BOCSILR will develop a job description and/ or a contract for the role of the Community Employment staff prior to commencing in their role. • Staff will complete a Health Declaration before they commence stating they are fit for the role. • Evidence of Induction by Person in Charge will be held on file.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Fire Safety building compliance remains a high priority for the BOCSI and BOCSILR.
• In relation to the registration condition in place for Regulation 23 a timeline for Le Cheile to come into compliance has been rolled out and will be completed by Q4 2023 as part of the Bawnmore plan agreed with HIQA.
• Risk assessment is in place for fire safety and all preventative measures continue to be followed within the designated centre.
• PEEP's plans in place for all residents.
• First responders training has being completed.
• Specialised Fire Marshall and PPE training completed with first responder staff on the 27/09/2023 and the 04-10-2023.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A timeline for Le Cheile to come into compliance has been rolled out and will be completed by Q4 2023 as part of the Bawnmore plan agreed with HIQA.
• The Head of Integrated Services and the Assistant Director of Nursing meet with the facilities team bi-weekly to discuss and prioritize works to be completed in the designated centre.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire Safety building compliance remains a high priority for the BOCSI and BOCSILR.
• In relation to the registration condition in place for Regulation 28 a timeline for Le Cheile to come into compliance has been rolled out and will be completed by 31/12/2023 as part of the Bawnmore plan agreed with HIQA.
• Risk assessment is in place for fire safety and all preventative measures continue to be followed within the designated centre.
• PEEP's plans in place for all residents.
• First responders training has being completed.
• Specialised Fire Marshall and PPE training completed with first responder staff on the 27/09/2023 and the 04-10-2023.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Medications that had expired returned to the pharmacy on the 19.10.2022.
• PIC discussed with the staff nurses & CNM1 at weekly house meeting on the 14.11.2023 & 15.11.2023 the importance of ensuring no out of date medications are stored in the medication presses.
• Meeting with the pharmacy held 15/11/2023 to discuss labelling systems and products that require out of date labels going forward.
• Expiry label will be printed on the pharmacy label.
• Pharmacist outlined that naming each generic and brand name drug is not feasibale as due to current Irish stock levels, they are continuosuly changing.
• This will be kept under review with the pharmacy.
• Irish Medicines Formulary is now available in each house for Staff Nurses to check if there are any queries with generic and brand names.
• The pharmacist clarified this is an adequate control, and no medication errors have occurred due to generic and brand names being used.
• Quarterly medication audits are ongoing as per BOCSI Policy.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Brothers of Charity Services Ireland Limerick Region (BOCSILR) has a Policy (Policy on the Handling of the Personal Assets of Adults Supported by the Services) in place which governs how we support Adults Supported by the Services with the management of their personal assets.
• This Policy is necessary to ensure that the rights and entitlements of the People Supported by the Services in relation to personal property and money are respected and protected by all people in the Services and that a safe system of working is provided for staff to ensure that they are not open to allegations of mishandling the monies or assets of the People Supported by the Services.
• The first step in the application of this Policy is to discuss it with the Person Supported to support them to make a decision on whether they wish to have the support of the BOCSILR with the management of their personal assets and, if so, to complete a consent process in respect of same. Where an individual does not understand this process a decision is reached in consultation with those who know them well based on best

interpretation of will and preference, and / or in good faith and for the benefit for the person.

• In advance of the rollout of the Policy on the Handling of Personal Assets of Adults Supported by the Services the BOCSILR linked with all of the principal financial institutions in the country in an effort to identify a product offering that would allow staff to provide the required support to People Supported by the Services.

• After much research, the only available product identified by the BOCSILR was the Person-In-Care account product offered by Allied Irish Bank.

• The Person-In-Care Current Account mandate allows for a maximum of two possible authorised signatories. The mandate does not allow for the Person Supported by the Services to be an authorised signatory on their Person-In-Care account. The Services recognise that some People Supported by the Services may wish to have more autonomy on their bank account, while also wanting to have support, and so have included Appendix 2(a) on the consent process. Where Appendix 2(a) has been agreed during the consent process staff will complete Appendix 2(b), with the Person Supported by the Services, in advance of withdrawing money. The Keyworker will act on this instruction. The authorised signatories on all Person-In-Care Current Accounts within the BOCSILR are the relevant Key Worker and the relevant PIC. Only one authorised signatory is required for each transaction and the expectation is that the Key Worker would support the Person Supported by the Services with the majority of transactions with the PIC being available in the event that the Key Worker was not available.

• As only one possible banking product has been identified, there is, unfortunately, no option for People Supported by the Services to have choice and freedom to exercise control in respect of bank accounts where they wish to be supported by BOCSILR staff with their finances.

• The address to which the bank statements are sent is also governed by the mandate but each bank statement is scanned and forwarded for inclusion in the personal financial file of the relevant Person Supported by the Services in a timely manner.

• A restrictive practice document is being developed to reflect the restrictions currently in place in respect of operations of Bank A/Cs for the people supported which will include Bank Statements.

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	07/11/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/12/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/12/2023

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in Schedule 2 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/01/2024
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	31/12/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	31/12/2023

Regulation 29(3)	The person in charge shall ensure that, where a pharmacist provides a record of a medication-related intervention in respect of a resident, such record is kept in a safe and accessible place in the designated centre.	Substantially Compliant	Yellow	30/11/2023
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Substantially Compliant	Yellow	31/01/2024