Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Saoirse
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	17 October 2023
Centre ID:	OSV-0004767
Fieldwork ID:	MON-0041469

About the designated centre

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

This designated centre is based on a large campus setting within the environs of Limerick city. There has been a number of re-configurations of this designated centre in recent years. Currently the centre is comprised of three bungalows and is registered to support a maximum of 12 residents. Adults both male and female with a diagnosis of intellectual disability are supported in this designated centre. One bungalow can accommodate four residents. This bungalow consists of four individual apartments. Three of the apartments have access to communal dining and living areas. There is also a kitchen, staff office and staff room. The second bungalow is comprised of five bedrooms, one of which has an en-suite, another has a small sitting room area, a kitchen, dining room and two large sitting room areas. This bungalow also has staff office, bathroom and toilet facilities. There is also an enclosed garden area and an adjoining apartment with a sitting room, bedroom and wheelchair accessible en-suite. The third bungalow has three individual bedrooms, a kitchen, dining room, sitting room, relaxation/visitor room, bathroom and additional toilet area, utility and staff office. There is also an enclosed garden area with parking at the front of the property. Residents are supported by a staff team comprised of nurses and health care assistants by day and night. Residents can avail of the on-site services such as day services, swimming pool, gym, church and multidisciplinary team support.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 17 October 2023	10:40hrs to 17:30hrs	Elaine McKeown	Lead
Tuesday 17 October 2023	10:40hrs to 17:30hrs	Lucia Power	Support

What residents told us and what inspectors observed

This was a short announced inspection of the designated centre to monitor the provider's compliance with the regulations and inform the decision regarding the renewal of the registration of the designated centre.

One inspector visited all three of the houses during the inspection and was able to meet with ten of the residents. All three houses were found to have been adapted, decorated and reflective of the interests of the individuals living in the houses. Each staff team were flexible to ensure the assessed needs of the residents in their care was being supported. The inspector was informed one resident had left in the afternoon to attend their senior citizen club in the local community when the inspector visited their home. Another resident was resting in their apartment at the time the inspector was visiting the adjacent house.

The inspector was introduced to three residents living in one of the houses during the morning. One resident sought assurance that the inspector would not be entering their living space and bedroom. This assurance was provided by the inspector and the staff present. The resident did sit down in the office and spent some time engaging with the inspector. Staff members present at the time encouraged the resident to talk about the activities they liked to do which included purchasing items in shops and going for spins in the community. Staff outlined to the inspector the importance for all of the residents in this house to have a regular routine. The residents were supported to attend activities weekly which included swimming, art therapy, mindfulness yoga and spins in the community to preferred locations. Additional activities were also organised by the provider on the campus in which this designated centre was located. Residents were supported to regularly attend an activity hub on the campus. Group activities such as a day trip to Government buildings and a masked ball were planned for the weeks after this inspection. A number of the residents also had regular contact with family members. A weekly visual schedule was available for each of the residents to inform them of planned activities on each day of the week.

The inspector visited the second house in the early afternoon. Three residents were being supported by two staff at the time. The staff were observed to respond to gestures and vocalisations made by the residents. The staff outlined the improvements for the residents which had taken place since the inspector last visited the house during the previous inspection in August 2022. One resident had moved to a bigger, brighter bedroom and additional communal space was available in a sensory room which was previously a bedroom. Some general maintenance and painting had taken place which assisted in creating a homely atmosphere for the residents. One resident was observed to be sitting in a chair in the sitting room which staff explained had been rented in advance of purchasing to ensure it suited the needs of the resident. The inspector observed this resident to be smiling and appear comfortable in the chair as staff were speaking about the benefits of the chair for the resident. Staff spoke of the many regular activities that the three

residents enjoyed both in the house, on the campus and in the wider community. These included hand massages, swimming and maintaining relationships with peers and family. Residents had also enjoyed train journeys and visits to wildlife parks during the summer months. The staff team had advanced plans made for two residents to visit a Christmas market and stay overnight in a large town. Staff had a dedicated transport vehicle which enabled them to plan and organise activities to suit the small group or individual activities. The inspector was also informed one resident regularly went home to spend time with family members at weekends.

On arrival at the third house the inspector was greeted with a firm handshake from one of the resident's. They were very proud of their home and assisted with a number of household chores. Two staff members were supporting the four residents who were present at the time. Staff outlined the preferred household chores each resident participated in, this included assisting with meal preparation and cleaning. One resident was observed to remove a wet floor sign after the area had been cleaned and dried while the inspector was present.

Residents in this house were supported to engage in independent activities which included three of the residents enjoying walks around the campus setting. Staff explained that during the public health restrictions a number of the residents in this house were observed to be less anxious and enjoyed an daily routine which had an approach akin to retired persons. Each of the residents had their own individual daily planner that suited their personal interests and wishes. For example, one resident liked horse racing and using betting slips. This was part of the resident's weekly activities and they had a goal to attend a horse racing event . Another resident had been supported to hire a suit to attend a wedding of a close family member. They had enjoyed this event very much. The staff team outlined how during 2022 another resident started speaking about particular named relatives. These were previously unknown to the staff team but had since been successfully located and were in regular contact with the resident.

Staff outlined how alternative activities were available if a resident was unable or expressed a wish not to complete a planned activity. For example, due to poor weather on the day of the inspection, one resident could not go out for their daily walk. Staff offered the resident a foot massage which they had enjoyed and was observed by the inspector to be smiling at staff when they were explaining this to the inspector. Residents had also participated in a dog therapy session on the morning of the inspection. Staff spoke of the many different activities which residents frequently engaged in which included sensory baking and reflexology in their home. On the campus residents could participate in bingo and art therapy and community activities included eating out in restaurants, attending concerts and shopping. One resident liked to assist the priest at Mass and another liked to socialise in a pub. These preferences were facilitated by the staff team

The inspector observed the residents interact positively with the staff present during the inspection. It was evident from a number of observed interactions that the person in charge was known to all of the residents who were met during this inspection. Staff spoken too were aware of the individual preferences and assessed needs of the residents. Each of the houses responded to the different assessed

needs of the individuals living there. For example, while residents in one of the houses preferred regular routines which followed visual schedules, residents in another house did not require the same visual input and were supported to effectively communicate and engage with staff expressing their wishes and preferences.

Staff spoke of the positive impact for three residents in one of the houses due to a reduction in the number of residents living in the house since the previous inspection in August 2022. However, they were also monitoring the changing needs of a number of residents in all of the three houses. These included increased supports required with mobilisation and activities of daily living (ADLs). Staff spoke of the ongoing input and involvement of the multi-disciplinary team (MDT). The input of day services staff allocated to the houses was also described as a positive restructuring of the services provided to individual residents which facilitated more frequent individual activities and access to more community and social activities. This was described by staff as resulting in a more meaningful day for residents.

The provider was actively progressing with plans to upgrade premises and fire safety on the campus which included this designated centre. The residents in one of the houses in this designated centre were scheduled to move to another house on the campus in the weeks after this inspection while extensive upgrade works were being carried out on their current home. This was expected to take a number of months to complete but was in -line with the provider's project plan submitted to the Chief Inspector.

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

Capacity and capability

Bawnmore campus is made up of five centres, with each centre having an additional condition. The non-standard condition attached to the registration of Saoirse is the provider shall address the regulatory non compliances as outlined in the plan dated 21 September 2020 to the satisfaction of the Chief Inspector no later than 5 January 2024 pertaining to fire and premises.

Premises and fire precautions continued to be not compliant on this inspection, however the provider had assessments in place to mitigate the risk. The campus was inspected over a two day period with each centre been inspected as per the Health Act 2007 and the regulations.

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 provider's overall plan 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.

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.

It was also evident that there was an increased focus on the lived experience for residents despite the current environmental constraints.

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.

It was noted that residents had bank accounts with the one banking organisation and that bank statements went to the provider's business address. Clarity was sought in relation to the residents' 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 rights.

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.

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.

Improvements were required in relation to Regulation 21: Records. A sample of staff files were reviewed for staff employed by the provider, with 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.

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 along with the required prescribed documents.

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. This was required to be updated by the provider and re-submitted to the Chief Inspector.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had ensured that a person in charge had been appointed to this designated centre. This person worked full time with their remit over this designated centre. On the day of the inspection they demonstrated their awareness of their role and responsibilities. The person in charge was familiar with the residents' assessed needs and clearly outlined the individual health and social care needs of the residents living in this designated centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that core staffing resources, including day service staff were allocated to the designated centre. There were no staff vacancies at the time

of this inspection. There were regular relief staff available who were familiar with the assessed needs of the residents for whom they were providing support to fill gaps in the staff rota at times of staff training, planned and unplanned leave. The staff team demonstrated their flexible approach to supporting residents to attend activities such as concerts and sporting fixtures in the community.

However, the allocation of shared staff resources in the evening time in the designated centre and on the campus was found to not be accurately reflected on the actual or planned rota. In addition, a number of residents required two staff to support them with activities of daily living. Following a review of the actual and planned rotas it was unclear when staff providing support in the evening time were present in a particular house. For example, a staff was rostered to be working in one of the houses from 20:30 hrs- 23:00 hrs but also provided support to other houses on the campus which may not be part of this designated centre. The inspector was informed the night time staffing resources were being managed by the clinical nurse managers on nights on the campus.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured all staff in the designated centre had completed a range of training courses to ensure they had the appropriate levels of knowledge and skills to best support the residents. These included training in mandatory areas such as fire safety and safeguarding of vulnerable adults. The provider ensured there was a scheduled and planned training matrix for 2023. This was frequently updated to reflect the status of training requirements for the staff team. Refresher training was booked in advance of the previous training expiring by the person in charge.

The provider had ensured that staff had access to training that was identified as important for this centre and in-line with residents' assessed needs including manual handling, safety intervention training and positive behaviour support awareness. In addition, the provider was reviewing the training requirements for all staff relating to Human rights at the time of this inspection.

The supervision of staff was scheduled for 2023 and in progress by the person in charge.

Judgment: Compliant

Regulation 21: Records

The provider had ensured that records of the information and documents in relation to staff specified in Schedule 2 were in place and available for inspectors to review. A sample of staff files were reviewed during this campus based inspection of staff employed by the provider.

However, there was not a clear process for people working in the centre who were on a CE scheme who carried out the same functions as some of the staff team and were reflected on the statement of purpose as part of the staffing compliment.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider ensured the designated centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

There was evidence of good oversight and systems were in place to ensure a safe, consistent and person centred service was provided in this designated centre. There were arrangements in place to monitor the quality of care and support provided in the designated centre. There was documented evidence of plans in place to address actions that had been identified in various audits that had been completed which included six-monthly unannounced provider-led audits as required by the regulations. In addition, the provider had ensured an annual review had also been completed.

Saoirse has an additional condition of registration in place, that the provider shall address the regulatory non compliance's as outlined in the plan dated 21 September 2020 to the satisfaction of the Chief Inspector no later than 5 January 2024. The provider has had delays in meeting this condition and there has been extensive regulatory engagement between HIQA and the provider since 2021. As the provider has had significant delays in progress with the overall fire safety plan and meeting the requirements of the condition by January 2024, assurance was not provided at the time of this inspection that this requirement would be met.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was prepared for the designated centre and subject to regular review. It reflected the services and facilities provided at the centre. Some minor changes were also completed by the person in charge during the inspection.

The provider was informed during the feedback at the end of the inspection that further review of the document was required in relation to the governance arrangements for night time staffing to ensure an accurate reflection was provided in the document. This was required to be updated by the provider and re-submitted to the Chief Inspector.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the quality and safety of care provided for residents was of a good standard. Residents' were being encouraged to build their confidence and independence, while exploring different activities and experiences.

The provider and person in charge supported and encouraged residents' opportunities to engage in activities in their home or in the local community. From meeting with residents, speaking with staff, and from a review of a sample of residents' assessments and daily records, the inspector found that residents had regular opportunities to engage in meaningful activities both inside and outside of the centre. They were attending activities, day services, using local services, and taking part in local groups. In addition, residents were encouraged to participate in household chores which included laundry, meal preparation and cleaning activities.

All residents had personal care plans that were reflective of each individuals assessed needs and the supports they required. Some plans contained photographs of the resident during the year engaging in different activities both within the designated centre and in the community. Residents were also supported by a key worker who was a familiar member of staff. The person in charge ensured there was an effective system in place for all plans to be reviewed as required but no less frequently than annually. A number of residents had ongoing input and support from family representatives.

Residents were supported to identify personal goals that were reflective of their interests. For example, residents were supported to engage in activities in the community, attend concerts and sporting fixtures and to increase social interactions within the community such as attending hairdressers/ barbers. However, the documenting of the progress of these goals was not consistent, with limited information provided in some instances. One resident had a goal of going on a social outing to a particular location. The limited detail documented included the resident had declined on two occasions but the dates of these were not recorded and had a positive experience on two occasions but no further details provided. Another

resident had a number of personal goals which included social activities however, they also had a goal of meeting with relatives but this was occurring regularly in their weekly planner.

Regulation 13: General welfare and development

Residents were being supported to access facilities for recreation, maintain relationships with peers and family and develop relationships with the wider community in line with their interests.

Residents were provided with opportunities to engage in meaningful activities both within their homes, on the campus in the day services hub or in the community. Residents were supported to engage in a range of activities regularly which included art therapy, swimming, sensory baking, walking, attending concerts and sporting events as well as listening to music. While routines were important to a number of residents in this designated centre, staff ensured all residents were kept informed of planned activities and any changes that may need to take place due to unforeseen circumstances such as poor weather conditions. For example, on the day of the inspection, one resident was unable to go out for their planned walk due to the weather so staff supported the resident to have a foot massage.

Judgment: Compliant

Regulation 17: Premises

All of the premises in this designated centre had evidence of personalised decor and furnishings to create a homely atmosphere. Each bungalow reflected the interests of the residents living there. For example, bedrooms were personalised and painted in colours which individual residents were known to like. However, some areas required maintenance as part of the upgrade works contained within the provider's overall plan for the campus. The inspector acknowledges that residents from one of the bungalows were scheduled to move to another bungalow on the campus in the weeks after this inspection while planned upgrade works were been carried out on their home.

Judgment: Not compliant

Regulation 28: Fire precautions

There was inadequate fire containment measures in all of the bungalows in this

designated centre at the time of this inspection.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge has systems and practices in place regarding medicines and pharmaceutical services within the designated centre. Staff spoken too during the inspection were knowledgeable on medicine management procedures and the reasons medicines were prescribed for individual residents. Medicine records that were reviewed were found to be complete. Medicines were securely stored in a locked press in each of the houses.

However, on the day of the inspection the correct storage of liquid medicines was found to be not consistent throughout the designated centre. For example, the date of opening was not documented on medicine bottles that were in use in one of the houses visited during this inspection. It was unclear/unknown if these medicines were out of date at the time of the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The registered provider had in place a personal plan for each resident that reflected the nature of their assessed needs and the supports required. The provider ensured there was input from the MDT as required. Each resident had a key worker who supported them to access their personal plan in an accessible format.

Residents were being supported to participate in meaningful activities which included over night stays and short breaks in different locations. In addition, residents could attend yoga, sensory baking and art therapy, if they wished. Alternatives were offered if residents declined to attend scheduled activities. For example, one resident explained to staff they preferred not to go to concerts and this was documented with alternative music options provided to the resident in -line with their expressed wishes. Residents were also supported to become involved in activities in which they had interests which included assisting at Mass.

However, the documenting of the progress and regular review of personal goals required further review. Not all residents had evidence documented that they had been supported to attain their goals. Some records lacked details of progress made to date while others had been completed but no evidence of extending the goal or developing an alternative for the resident were documented.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had ensured all staff had been provided with training to ensure the safeguarding of residents. Information was available for residents in easy- to– read format. There were no open safeguarding concerns in this designated centre.

In addition, each resident had an up-to-date intimate care plan that were subject to regular review which detailed the supports required in this area for the resident.

Judgment: Compliant

Regulation 9: Residents' rights

In line with the statement of purpose for the centre, the inspector found that the diversity of residents were being promoted in each of the houses within the designated centre. Each of the houses had been decorated to reflect the individual personalities of those living in the house. Residents were consulted about the running of the designated centre, information was shared and choices were discussed in a format understood by the residents, such as with visual aids or verbal communication.

Over the course of the inspection, residents were observed to be supported professionally and with respect by the staff team. Staff on duty were observed to use a variety of communication supports in line with residents' individual needs. Staff practices were noted to be respectful of residents' privacy. For example, they were observed to knock on doors prior to entering, to keep residents' personal information private, and to only share it on a need-to-know basis.

Residents had access to information on how to access advocacy services and were supported to access information in relation to their rights, their responsibilities, safeguarding, and accessing advocacy supports. There was information available in an easy-to-read format on the centre in relation to a number of topics including safeguarding and infection prevention and control.

However, all residents had bank accounts with one banking organisation and residents' bank statements went to the provider's business address. The provider did not have any evidence to support that the residents were involved/consulted in the selection of a bank of their choosing and had the freedom to exercise control in 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 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Saoirse OSV-0004767

Inspection ID: MON-0041469

Date of inspection: 17/10/2023

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: • Protocols put in place by the Night Managers on the 19-10-2023 in relation to the requirement for a staff from the Saoirse Designated Centre to support houses in Saoirse and other designated centers for People and Manual Handling and medication rounds. • WTE's reviewed in relation to the twilight staffing and adjusted for in SOP. • Statement of Purpose resubmitted to HIQA on the 06-11-2023	
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.	
Regulation 23: Governance and management	Not 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 Saoirse to come into compliance will be rolled out and completed by Q1 2026 as part of the Bawnmore plan agreed with HIQA. • Four residents from Gardenview will transfer to another designated. Upgrade works will commence in Gardenview. • Five residents in Cedar drive 6 will transfer to a community house in Pallasgreen by Q1	

2026 and Cedar 6 will close.
• Two residents in Cedar 5 will transfer to another designated centre. One resident is planned for transfer to community house. Cedar 5 will close and the footprint will be removed from the designated centre.
• The revised date for Pallasgreen was confirmed by HSE on 9th November 2023 as Q1 2026.
• 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	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Fire Safety building compliance remains a high priority for the BOCSI and BOCSILR.
• In relation to the registration condition in place for Regulation 17 a timeline for Saoirse to come into compliance will be rolled out and completed by Q1 2026 as part of the Bawnmore plan agreed with HIQA.
• Four residents from Gardenview will transfer to another designated. Upgrade works will commence in Gardenview.
• Five residents in Cedar drive 6 will transfer to a community house in Pallasgreen by Q1 2026 and Cedar 6 will close.
• Two residents in Cedar 5 will transfer to another designated centre. One resident is planned for transfer to community house. Cedar 5 will close and the footprint will be removed from the designated centre.
• The revised date for Pallasgreen was confirmed by HSE on 9th November 2023 as Q1 2026.
• In the interim continuous efforts to facilitate minor upgrades will continue.
• 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	Not 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 23 a timeline for Saoirse to come into compliance will be rolled out and completed by Q1 2026 as part of the Bawnmore plan agreed with HIQA.
• Four residents from Gardenview will transfer to another designated. Upgrade works will commence in Gardenview.
• Five residents in Cedar drive 6 will transfer to a community house in Pallasgreen by Q1 2026 and Cedar 6 will close.
• Two residents in Cedar 5 will transfer to another designated centre. One resident is planned for transfer to community house. Cedar 5 will close and the footprint will be removed from the designated centre.
• The revised date for Pallasgreen was confirmed by HSE on 9th November 2023 as Q1 2026.
• 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:
• 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.
• Medication policy discussed at weekly meetings 22/11/2023 and 29/11/2023.

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:
• The documentary evidence required for the progression of goals for individuals we support discussed at staff meetings on the 14.11.2023 & 21.11.2023.
• All goals identified to be progressed with accurate timelines recorded.
• Staff will record if the goal was completed & if the goal was successful or unsuccessful.
• If the goal was successful, this goal will form part of the resident's daily activities.
• Date of commencement of next goal to be discussed with the residents and recorded as part of the PCP process.
• PIC will review all PCPs with keyworkers to ensure goals and timelines are recorded accurately.

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	06/11/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/03/2026
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	Substantially Compliant	Yellow	31/01/2024

	inspection by the chief inspector.			
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.	Not Compliant	Orange	31/03/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2026
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	30/11/2023

Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/01/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	31/01/2024