Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	East Limerick Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	23 March 2022
Centre ID:	OSV-0004779
Fieldwork ID:	MON-0034638

About the designated centre

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

East Limerick Services consists of four detached single storey houses. Three of these houses are located close together on the outskirts of a village while the other is located 15 minutes drive away in a more rural location. The designated centre can provide a full-time residential services for up to 15 residents of both genders with intellectual disabilities who are over the age of 18 years. Individual bedrooms are available for residents and other facilities throughout the houses of this centre include bathrooms, sitting rooms, kitchens, dining rooms and staff rooms.
Support to residents is provided by the person in charge, clinical nurses managers, staff nurses, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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 23 March 2022	10:05hrs to 19:10hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

The residents met during this inspection either gave positive feedback to the inspector or appeared content in their environments. Appropriate support was provided to residents by the staff members present, who were seen to engage with residents in a positive and warm manner throughout the inspection. All residents had their own individual bedrooms within the houses where they lived with such houses generally seen to be homely and well maintained, although some areas in need of improvement were noted.

During this inspection, three of the four houses that made up this designated centre were visited by the inspector. These three houses were located close together on the outskirts of a village with four residents living in each of these houses, all of whom were met by the inspector. While some of these residents spoke with the inspector, others did not engage directly, but the inspector did have some opportunities to observe these residents in their environments and in their interactions with staff members present. The inspector was also able to speak with the staff members supporting these residents. Only one resident lived in the fourth house, which was not visited as part of this inspection and the resident was not met by the inspector.

Upon arriving at the first house visited, the inspector met one resident as they were seating in the reception area. This resident informed the inspector that they were waiting for a bus to take them to a day service where they would meet their friends. The resident attended this day services every Monday and Wednesday, but also went to a different day service run by the provider of this designated centre, on Fridays. When asked by the inspector if they liked living in the centre, the resident said that they did and they were aware of those involved in the management of the centre. The resident also informed the inspector that they were a secretary for the centre and helped in answering telephone calls. Shortly after, a bus arrived to collect the resident and they left the centre.

After an introduction meeting with management of the centre, the inspector spent most of the initial part of this inspection moving between the three houses. In one of these houses the inspector spoke to another resident who said that they liked the centre and that there was nothing more that they could want. The resident talked about going to meet a family member at the weekend and said that they used one of the centre's vehicles to go for drives and to go to shopping centres. The staff members supporting them were commented upon positively by the resident, who also indicated that they liked the other residents that they were living with. One of these residents was briefly met as they were being supported with eating, by a staff member. This resident did not interact with the inspector but it was noted that the assistance from the staff member was provided in an appropriate manner.

Later during the inspection, the other two residents that lived in this house were also met by the inspector. One of these residents did not engage with the inspector

but appeared calm and was seen to be supported by a staff member to go for a drive and attend a hairdressers in the community. The other resident was met on multiple occasions as they sat at their own desk, which had been personalised for them, in a large day room that was connected to the house where they lived. Upon first meeting the inspector, the resident though that the inspector was a doctor. The inspector informed the resident that they worked with the Health Information and Quality Authority (HIQA) and that they were in the centre to see how the residents were doing. When asked by the inspector how they were getting on, the resident responded that they did not know and talked about an injection they had received previously. Throughout this inspection this resident was seen at their desk and appeared either content or happy when seen by the inspector.

Another house was visited twice by the inspector, where all four residents living there were met. The staff present were seen to interact very warmly with the residents. For example, one staff member was seen using electronic tablet devices to put on some music videos for one resident and to show another resident photographs of a hotel that the resident would be going to, for a future advocacy group meeting. One of the residents indicated to the inspector that things were good, while another resident used various hand gestures to communicate, which the staff present appeared to have a good understanding of. The remaining two residents of this house were also met neither of whom interacted with the inspector. On both visits to this house it was noted that one resident in particular remained seated in the sitting room area watching television. Later on during the inspection, all residents living in this house left the centre to go for a drive to one of the provider's day service areas, using two of the centre's vehicles.

Upon initially visiting the third house, the inspector met three residents. None of these residents engaged directly with the inspector but all appeared either content or happy. One staff member present informed the inspector they had taken one of the residents out for a haircut earlier in the day and that they would be taking all three residents out for a drive later in the day. Towards the end of the inspection, the inspector returned to this house and was informed that this drive had taken place. The resident that the inspector had met at the outset of this inspection lived in this house and had returned there following their time at their day services. The inspector was informed by the resident that they had won at bingo in the day services and won some money as a result. At this time the resident was watching television and said that they would be relaxing for the evening. The staff present was seen to engage pleasantly with residents at this time.

As the inspector moved between the three houses visited during this inspection, it was observed generally that the houses were clean, homely and well-furnished with residents having their own individual bedrooms, which were noted to be brightly decorated and personalised. However, the inspector did note that a part of the ceiling in a hall area appeared damaged in one house. In another house, some mould was seen in the bedroom of one resident, while it was observed that a number of fixtures in the three bathrooms, such as grab rails, were either dusty, dirty or visibly worn. One of these bathrooms was also being used for storage purposes. In the same house, the inspector initially observed some clothes left on the laundry room floor, but these were later seen to be removed. In one house, the

inspector noted that a sign on display indicating that certain colour coded cleaning equipment, such as mops, were to be used in certain rooms (for example, red equipment was to be used for bathrooms and yellow equipment to be used for bathrooms). Each of the three houses visited had storage facilities for such cleaning equipment but it was noted equipment was outside the houses, exposed to the elements, with some seen to be stored in a disorganised way.

After the inspector had completed much of the observations and discussions with staff and residents, he focused primarily on a review of documentation towards the end of the inspection. Amongst the documents reviewed, were resident and family questionnaires completed in 2022, as part of an annual review process. Nine resident questionnaires had been completed, some with the support of staff members, with generally positive responses provided to areas such as staffing and safety. It was noted though that two questionnaires made reference to residents wanting more 1:1 time from staff. Six family questionnaires were reviewed which asked questions on areas such as residents' needs and staffing. Four of the questionnaires gave very positive responses overall with one stating "we appreciated the excellent level of care provided". However, two family members had provided some negative feedback, with one saying that the house where their relative lived was institutionalised. The other family member indicated that they wanted more community integration and did not know if their relative was safe.

In summary, the premises provided for residents to live in was generally found to be clean, well-maintained and homelike, although some areas were seen which needed improvement. The staff members present were seen to interact appropriately with the residents that they were supporting. The residents spoken with provided positive feedback to the inspector and while most resident and family questionnaires did contain positive feedback, some also contained some negative feedback or highlighted areas in need of improvement.

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

Some improvement had been made since the previous HIQA inspection. However, regulatory breaches remained in the five regulations that were the primary focus of this inspection.

Prior to the current inspection, this designated centre had been inspected nine times by HIQA between January 2015 and September 2021. Throughout those inspections, recurrent areas of non-compliance had been identified. The most recent inspections for this centre had raised particular concerns regarding the following regulations; Regulation 9 Residents' rights, Regulation 13 General welfare and

development, Regulation 15 Staffing, Regulation 23 Governance and management and Regulation 28 Fire precautions. However, the registered provider's responses to such concerns for the January 2020 and September 2021 inspections did not adequately assure the Chief Inspector that proposed actions from the provider would result in compliance with these regulations. In light of this, the purpose of the current inspection focused primarily on these regulations.

Since the previous HIQA inspection in September 2021, there had been some managerial changes for this designated centre, which included the addition of a new member to the centre's management team. This was a positive development and was intended to provide additional support to local management. Such support had not been adequately provided by the registered provider for a number of years previously. The person had recently taken up the position and was present during this inspection, during which they outlined their plans to be actively involved in the running of the centre and to be a regular presence in the centre. Staff members spoken with during this inspection commented positively on the recent managerial changes, with one staff indicating that the current management were trying to be proactive and to put forward good solutions to address concerns.

Aside from this, it was also found that there were some improvements regarding the range of activities that residents could participate in. However, there were still challenges in this regard, which were contributed to by ongoing issues with the staffing arrangements in place to support residents. For example, it was highlighted that some residents had limited opportunities to be supported to engage in 1:1 activities of their choice given the supports that other residents needed and the other work tasks that staff had to undertake. There were also times when staff supporting residents in one house would have to leave that house to support residents in another house, which would limit the supports that could be provided to residents in the first house. It was also noted that a concern had been raised by staff working in this centre, that aspects of the staffing arrangements in operation were promoting some institutional practices, while there were some occasions where specific nursing shifts for this centre had not been filled.

While it was indicated that a roster review had recently taken place and efforts were being made to address the issues raised, the continued concerns around the staffing arrangements did not provide assurance that this designated centre was wholly appropriate to residents' assessed needs, nor that it was adequately resourced to ensure the effective delivery of care and support on a consistent basis. This was also evident given that the current inspection found ongoing regulatory breaches, in all five of the regulations which were the main focus of the inspection. Under the regulations, ensuring that a designated centre is appropriate to residents' assessed needs and adequately resourced to ensure the effective delivery of care and support, is the direct responsibility of the registered provider which for this centre is Brothers of Charity Services Ireland. It is also the registered provider's responsibility to ensure that it takes appropriate measures to ensure compliance with the regulations. Given this designated centre's history of compliance, this was something which was emphasised to the management of this centre, during a feedback session for the inspection. Failure to adequately address the concerns raised by the inspection could result in continued non-compliance, impacting the quality of service

that residents received and further regulatory activities being considered by HIQA.

Regulation 14: Persons in charge

The person in charge appointed for the centre at the time of this inspection had the necessary skills, experience and qualifications to perform the role.

Judgment: Compliant

Regulation 15: Staffing

There were some occasions where certain shifts in the centre, which were intended for nursing staff, had not been filled by nurses. The staffing arrangements in the designated centre were limiting residents' abilities to participate in some activities or receive support which was not in keeping with residents' assessed needs. A concern had been raised by staff working in the centre, that aspects of the staffing arrangements in operation were promoting some institutional practices. For example, it had been highlighted that a resident who required 2:1 support was put to bed earlier due to the the number of staff on duty.

Judgment: Not compliant

Regulation 23: Governance and management

While some improvement was noted during this inspection, continued regulatory breaches in specific regulations indicated that the registered provider had not ensured that this designated centre was wholly appropriate to residents' assessed needs, nor that it was adequately resourced to ensure the effective delivery of care and support on a consistent basis.

Judgment: Not compliant

Quality and safety

There was some evidence of increased community access for residents but the provision of consistent, meaningful activities for some residents, remained an area in need of improvement. Fire safety concerns remained regarding one house and

additional concerns were identified regarding the remaining three houses of this designated centre.

Staff members spoken with indicated that the level of community based activities for residents had improved in the recent months, although there had been challenges in this regard, partly due to the COVID-19 pandemic. During the inspection, some residents were noted to access of the local community, such as attending the local hairdressers. When reviewing records relating to all 12 residents in the three houses visited during this inspection, some community based activities were listed for residents such as shopping, meals out and attending mass. Activities within the residents' houses indicated baking, arts and crafts, pet therapy and music therapy. However, when reviewing these records, there were some variance to the level and nature of activities that some residents were participating in. For example, for one resident it was noted that the only activity they participated in on one day, was a foot massage, while there were days when some residents had no record of having participated in any activity. It was also noted that drives were the most commonly listed activity for residents.

With the lifting of COVID-19 restrictions, some of the residents of this centre had returned to day services, some of which were operated by the provider away from this designated centre. Other residents though did not have access to a day service within this centre and were reliant on staff to support certain activities. As highlighted earlier, the staffing arrangements did not always facilitate residents in this regard. For example, the inspector was informed that supporting residents for 1:1 activities was difficult with one staff highlighting that because of this, one resident spent much of their time watching television. The inspector visited this resident's house twice during this inspection and on both occasions the resident was seen watching television, but did leave the house later in the day with peers.

In addition, the transport available for this centre posed challenges. While each of the three houses visited during this inspection had their own vehicle, it was highlighted how each vehicle could only accommodate one wheelchair user. In some houses, more than one resident required the use of a wheelchair which posed the challenge. Efforts were made to plan the use of these vehicles and to share them between the houses. The difficulty in providing residents with 1:1 staff support and the transport challenges did limit residents' right to choose what activities they could partake in. It was observed that residents were treated respectfully by staff members present during this inspection, while there was evidence that staff were advocating on behalf of residents. For example, the inspector was informed that staff of the centre had engaged with a politician to raise an issue concerning the accessibility of footpaths in the local area. Residents were also supported to participate in fire drills which happened regularly.

It was noted that fire drills for one house, to reflect a times of minimum staffing, involving all four residents living there had not been conducted since January 2021. HIQA had raised particular concerns around the fire evacuation arrangements for this house at times of minimum staffing, during an October 2020 inspection. At the time of the current inspection, the designated centre had a restrictive condition of registration requiring the provider to come into compliance with Regulation 28 Fire

precautions by 31 December 2022. This condition was due to a lack of appropriate fire containment measures, such as fire doors, in one house of this centre and it was indicated that the provider was making progress in addressing this. However, during the current inspection, it was highlighted that all fire doors in the other three houses were to be replaced as part of a maintenance and upgrade programme. This suggested that appropriate fire containment measures were not present in these houses either. During the feedback session of the inspection, it was emphasised to management of the centre that the restrictive condition applied to the designated centre overall and not just one house.

Regulation 13: General welfare and development

While there was evidence of increased community participation for residents, opportunities for some residents to engage in meaningful activities on an individual basis remained limited. Some residents' daily activities were limited while on some days, some residents were not indicated as having participated in any activity.

Judgment: Not compliant

Regulation 17: Premises

While the houses visited by the inspector were generally seen to be clean, homely and well-maintained, it was noted that part of the ceiling in one house was damaged, there was mould in one resident's bedroom and some bathroom fixtures were either dirty, rusty or visibly worn.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

This regulation was not reviewed in full but during this inspection it was highlighted that three members of staff had been subject to a derogation process. The derogation of staff in the context of COVID-19 involves an exemption from adherence to national guidance. This is a potentially high risk activity and must only be considered through a risk assessment process with authorisation from senior management. There was some evidence that such measures had been followed, however, individual risk assessments for the staff involved had not been completed in full and had not been signed off to conclusion by senior management.

Judgment: Substantially compliant

Regulation 27: Protection against infection

This regulation was not reviewed in full but during this inspection it was noted that while staff were generally wearing respiratory masks as required by national guidance for all resident care activities, during the early part of the inspection, one staff member was seen not to be wearing such a mask when they should have been. Risk assessments were also in place regarding some other staff members not wearing respiratory masks when supporting residents. These risk assessments indicated that these staff were to wear surgical masks only, provided there were no COVID-19 concerns, but that staff also had to additionally wear visors, if there were COVID-19 concerns. The centre had a contingency plan in place related to COVID-19, which had been implemented regarding staffing, owing to recent COVID-19 related concerns. The storage and management of colour coded cleaning equipment required improvement, as observation on the day indicated that best practice was not employed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Appropriate fire containment measures were not provided throughout the four houses that made up this designated centre. A fire drill for one house to reflect a minimum staffing simulation that involved all four residents living there, had not been conducted since January 2021. A quarterly maintenance check for emergency lighting was overdue at the time of the inspection.

Judgment: Not compliant

Regulation 6: Health care

This regulation was not reviewed in full but during this inspection. The inspector was informed that one resident did not have a wheelchair that was suited to their assessed needs and this had been the case for over a year. While staff had made efforts to address this, a review required by an occupational therapist relating to the resident, had not taken place at the time of the inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Some residents' choice and control over their daily lives was reduced due to limits on the range of activities they could participate in. It was seen though that staff members treated residents respectfully throughout this inspection and efforts were being made to promote residents' rights.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for East Limerick Services OSV-0004779

Inspection ID: MON-0034638

Date of inspection: 23/03/2022

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. Staffing levels are reviewed on continuous basis and we continue to endeavor to provide consistent staffing day and night whilst also complying with public health requirements relating to COVID. Absence levels as a result of COVID has been high since December but is beginning to normalize.
2. Head of Integrated Services is now present in Doon a minimum of 2 days per week, except for periods of annual leave, in order to support the PIC and staff in respect of embedding a culture of person centredness. It is recognised that good progress has taken place to date and this important work will continue to be supported.
3. Head of Integrated Services and PIC have met with staff on 11th May 2022 to outline changes to the roster which will involve the transfer of staff within the centre. It is anticipated that the change of staff within the centre will offer greater opportunities to improve the quality of life of residents.
4. Part of the change in roster, is to change one roster to 10am and 10pm that will support the evening routine. This will take up to 6 weeks to implement and will be in place by 30th June 2022.
5. Business cases (for twilight staffing and day staffing to support meaningful activities for residents) were discussed at meeting with the funder on 16th May 2022 and resubmitted as a combined business case with supporting risk assessments in respect of compliance on 17th May 2022. HSE confirmed it will be escalated for consideration regarding funding at meeting with HSE Senior Management on 18th May 2022. We have been advised that the business case will now be escalated for review by the Chief Officer at the June emergency meeting. The BOCSILR has no control on the outcome of this meeting and therefore we cannot attach a date to this action.
6. A risk assessment is in place for instances when the night nurse shift cannot be filled and a HCA is used instead. This is evidenced in the SOP.
7. Staff from other designated centres within Integrated Services are redeployed in order to fill the roster when required.
8. HR are actively recruiting nursing staff and relief care assistants.
9. 2 unfunded lines remain in place at present (Willowdale and Dromkeen) while awaiting

the outcome of the Business Cases submitted to the HSE. These unfunded staff were put in place as a result of high level safety risk.
10. Shift planner updated on 7th April 2022 to organise staffing on a daily basis.
11. A shift coordinator will be allocated daily to take the responsibility of tasks and activities being completed in each house in the designated centre. This commenced on 21st April 2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Head of Services will continue to visit the designated centred on a weekly basis to provide support and supervision to the management team.
2. PIC attends regular meetings with the wider Integrated Services team to share learning.
3. Rosters are supported across integrated Services.
4. Head of Integrated Services is now present in Doon a minimum of 2 days per week, except for periods of annual leave, in order to support the PIC and staff time in respect of embedding a culture of person centredness. It is recognised that good progress has taken place to date and it is agreed that this important work will continue to be supported.
5. Head of Integrated Services and PIC have met with staff on 11th May 2022 to outline changes to the roster which will involve the transfer of staff within the centre. It is anticipated that the change of staff within the centre will offer greater opportunities to improve the quality of life of residents.
6. Part of the change in roster, is to change one roster to 10am and 10pm that will support the evening routine. This will take up to 6 weeks to implement and will be in place by 30th June 2022.
7. Review of residents is also being actively planned by MDT with the support of PIC and PPIM based on feedback of residents and in an effort to address a number of compatibility issues within the centre. Recommendations will be made to the AMT committee by July 2022 and once approved transition plans will be drawn up. It is anticipated that the change of the living arrangements of residents within the 3 bungalows will enhance the quality of life of residents.
8. Business cases (for twilight staffing and day staffing to support meaningful activities for residents) were discussed at meeting with the funder on 16th May 2022 and resubmitted as a combined business case with supporting risk assessments in respect of compliance on 17th May 2022. HSE confirmed it will be escalated for consideration regarding funding at meeting with HSE Senior Management on 18th May 2022. We have been advised that the business case will now be escalated for review by the Chief Officer at the June emergency meeting. The BOCSILR has no control on the outcome of this meeting and therefore we cannot attach a date to this action.
9. A risk assessment is in place for instances when the night nurse shift cannot be filled

and a HCA is used instead. This is evidenced in the SOP.
10. 2 unfunded lines remain in place at present (Willowdale and Dromkeen) while awaiting the outcome of the business cases submitted to the HSE. These unfunded staff were put in place as a result of a high level safety risk.
11. SLT will provide support for staff commencing 14th April 2022 creating activity lists best suited to persons supported level of communication.
12. The approval for the upgrade of fire doors in the three houses was communicated to the Fire Safety engineer on 17th May 2022 based on his recommendation following the review of the successful tender. Work will progress once the underfloor heating is fixed.
13. Contractor has been appointed to fix the underfloor heating and parts have been secured. It is expected that this work will progress by 31st May 2022.
14. The tender for the upgrade of the newly purchased house in Doon has gone to tender and the tenders were opened on 25th April 2022. Tender recommendations were submitted to the Director of Services on 4th May 2022 and these were submitted to Limerick Council who is funding the house and the upgrade.
15. Limerick Council has advised on 17th May 2022 that they will be sending the application for additional funding to the Department of Housing. In this regard the Council has advised not to appoint a contractor until such time as we have been advised of the response from the Department.
16. We are confident that approval will be granted by 30th June 2022. As soon as approval is granted we will be in a position to instruct the successful contractor to commence the upgrade work under the supervision of the Fire Safety Engineer.
17. Fire Safety Engineer has been requested to review the specification for the upgrade of the Dromkeen House to ensure that there is no delay once the house is vacated.
18. Since inspection fire drills have been carried out in all houses within the designated centre.
19. The emergency lighting was checked on 30th March 2022
20. Steering group overseeing the roll out of PCP in the designated centre continue to meet to review progress.
21. Senior Management meet to review findings of 6 month unannounced inspections to ensure actions are being address and progressed where possible.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
1. Head of Integrated Services is now present in Doon a minimum of 2 days per week, except for periods of annual leave, in order to support the PIC and staff time in respect of embedding a culture of person centredness. It is recognised that good progress has taken place to date and this important work will continue to be supported.
2. Head of Integrated Services and PIC have met with staff on 11th May 2022 to outline changes to the roster which will involve the transfer of staff within the centre. It is anticipated that the change of staff within the centre will offer greater opportunities to

improve the quality of life of residents.
3. Part of the change in roster, is to change one roster to 10am and 10pm that will support the evening routine. This will take up to 6 weeks to implement and will be in place by 30th June 2022.
4. Review of residents is also being actively planned by MDT with the support of PIC and PPIM based on feedback of residents and in an effort to address a number of compatibility issues within the centre. Recommendations will be made to the AMT committee by July 2022 and once approved transition plans will be drawn up. It is anticipated that the change of the living arrangements of residents within the 3 bungalows will enhance the quality of life of residents.
5. Business cases (for twilight staffing and day staffing to support meaningful activities for residents) were discussed at meeting with the funder on 16th May 2022 and resubmitted as a combined business case with supporting risk assessments in respect of compliance on 17th May 2022. HSE confirmed it will be escalated for consideration regarding funding at meeting with HSE Senior Management on 18th May 2022. We have been advised that the business case will now be escalated for review by the Chief Officer at the June emergency meeting. The BOCSILR has no control on the outcome of this meeting and therefore we cannot attach a date to this action.
6. All activity recording sheets will be reviewed by the 30th April 2022.
7. Weekly staff meetings to review activities in individual houses commenced on 23rd March 2022 with the support of Head of Services.
8. SLT will provide support for staff commencing 14th April 2022 creating activity lists best suited to persons supported level of communication.
9. Weekly Residents House meeting's take place in each house. During this meeting persons supported have the opportunity to voice any concerns they may have.
10. The local complaints procedure is open to all persons supported and this is reviewed on a monthly basis by the CNM2. If the complaint cannot be satisfied locally it is escalated to senior management.
11. Transport in the designated centre currently being reviewed. Booking system to be implemented by 30th April 2022 should supports from a second transport be required. This will be discussed at the resident's house meetings to support activities.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The approval for the upgrade of fire doors in the three houses was communicated to the Fire Safety Engineer on 17th May 2022 based on his recommendation following the review of the successful tender. Work will progress once the underfloor heating is fixed.
2. Contractor has been appointed to fix the underfloor heating and parts have been secured. It is expected that this work will progress by 31st May 2022.
3. The tender for the upgrade of the newly purchased house in Doon has gone to tender and the tenders were opened on 25th April 2022. Tender recommendations were submitted to the Director of Services on 4th May 2022 and these were submitted to Limerick Council who is funding the house and the upgrade.

4. Limerick Council has advised on 17th May 2022 that they will be sending the application for additional funding to the Department of Housing. In this regard the Council has advised not to appoint a contractor until such time as we have been advised of the response from the Department.
5. We are confident that approval will be granted in the short term. As soon as approval is granted we will be in a position to instruct the successful contractor to commence the upgrade work under the supervision of the fire safety engineer.
6. Fire safety Engineer has been requested to review the specification for the upgrade of the Dromkeen House to ensure that there is no delay once the house is vacated.
7. Outdoor work to repair the roof has been completed since February 2022
8. Requests sent to maintenance department for repair of damage to ceilings caused by damp prior caused by damaged roof.
9. Cleaning checklist currently being reviewed. New Infection Prevention Control manual and Quality Improvement Tool will be completed by 30th April 2022.
10. All bathrooms have been reviewed for any damage or rusted bars and MRF sent 11th April 2022.
11. Sheds purchased for the storage and management of colour coded equipment.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. Individual risk assessments now completed in full and signed by senior management.
2. Risks will continue to be on the agenda between Head of Integrated Services and Administrator in Designated Centre.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. All staff have been informed on the importance of wearing FFP2 masks while on shift
2. Risks assessments in place for all staff who cannot wear FFP2 masks
3. Sheds purchased for the storage and management of colour coded equipment.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The approval for the upgrade of fire doors in the three houses was communicated to the Fire Safety Engineer on 17th May 2022 based on his recommendation following the review of the successful tender. Work will progress once the underfloor heating is fixed.
2. Contractor has been appointed to fix the underfloor heating and parts have been secured. It is expected that this work will progress by 31st May 2022.
3. The tender for the upgrade of the newly purchased house in Doon has gone to tender and the tenders were opened on 25th April 2022. Tender recommendations were submitted to the Director of Services on 4th May 2022 and these were submitted to Limerick Council who is funding the house and the upgrade.
4. Limerick Council has advised on 17th May 2022 that they will be sending the application for additional funding to the Department of Housing. In this regard the Council has advised not to appoint a contractor until such time as we have been advised of the response from the Department.
5. We are confident that approval will be granted by 30th June 2022. As soon as approval is granted we will be in a position to instruct the successful contractor to commence the upgrade work under the supervision of the fire safety engineer.
6. Fire safety Engineer has been requested to review the specification for the upgrade of the Dromkeen House to ensure that there is no delay once the house is vacated.
7. Since inspection fire drills have been carried out in all houses within the designated centre.
8. The emergency lighting was checked on 30th March 2022

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. East Limerick Services comes under the PCCC (Community and Primary Healthcare) and not under Integrated Services.
2. L 651 was referred to PCCC on 13th March 2021. The referral was based on the suitability of resident to access the community in his wheelchair given his weight and Manuel Handling concerns. It was noted that this was a barrier to community integration. The referral was declined by the Community Healthcare Team and they advised that the only equipment available to the residents in Doon is bespoke non-standard equipment.
3. This was escalated to the OT in Integrated Services on the 22nd July 2022. The OT in Integrated Services who does not support Doon services as it is not under her remit agreed to assess L651 in the Posture Clinic on 15th December 2021 unfortunately it was cancelled due to household Covid Contact.
4. Another appointment was scheduled on 10th March 2022 unfortunately this was cancelled due to L651 hospital admission.
5. Following inspection on the 23rd March 2022 the OT from Integrated Services was

contacted and assessed resident on 24th March 2022. Referral made on the 24th March 2022 to HC21 for residents back rest to be replaced. Referral made for comfort chair on 24th March 2022 as an alternative seating option. OT carried out assessment with Advanced Seating on 20th April 2022 to fit suitable comfort chair. Comfort chair in place 20th April 2022
6. Following inspection on 23rd March 2022 OT from Integrated Services followed up with the Primary Community and Continuing Care (PCCC) Team who are now accepting referrals for persons supported living in the East Limerick Services. Previously there were barriers in getting this service. Appointments for 5 persons supported commenced 13th April 2022.
7. Weekly staff meetings to review health and wellbeing in individual houses commenced on 23rd March 2022 with the support of Head of Services.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Head of Integrated Services is now present in Doon a minimum of 2 days per week, except for periods of annual leave, in order to support the PIC and staff time in respect of embedding a culture of person centredness. It is recognised that good progress has taken place to date and this important work will continue to be supported.
2. Head of Integrated Services and PIC have met with staff on 11th May 2022 to outline changes to the roster which will involve the transfer of staff within the centre. It is anticipated that the change of staff within the centre will offer greater opportunities to improve the quality of life of residents.
3. Part of the change in roster is to change one roster to 10am and 10pm that will support the evening routine. This will take up to 6 weeks to implement and will be in place by 30th June 2022.
4. Review of residents is also being actively planned by MDT with the support of PIC and PPIM based on feedback of residents and in an effort to address a number of compatibility issues within the centre. Recommendations will be made to the AMT committee by July 2022 and once approved transition plans will be drawn up. It is anticipated that the change of the living arrangements of residents within the 3 bungalows will enhance the quality of life of residents.
5. Business Cases (for twilight staffing and day staffing to support meaningful activities for residents) were discussed at meeting with the funder on 16th May 2022 and resubmitted as a combined business case with supporting risk assessments in respect of compliance on 17th May 2022. HSE confirmed it will be escalated for consideration regarding funding at meeting with HSE Senior Management on 18th May 2022. We have been advised that the business case will now be escalated for review by the Chief Officer at the June emergency meeting.The BOCSILR has no control on the outcome of this meeting and therefore we cannot attach a date to this action.
6. All activity recording sheets will be reviewed by the 30th April 2022.
7. Weekly staff meetings to review activities in individual houses commenced on 23rd March 2022 with the support of Head of Services.

8. SLT will provide support for staff commencing 14th April 2022 creating activity lists best suited to persons supported level of communication.
9. Weekly Residents House meeting's take place in each house. During this meeting persons supported have the opportunity to voice any concerns they may have.
10. The local complaints procedure is open to all persons supported and this is reviewed on a monthly basis by the CNM2. If the complaint cannot be satisfied locally it is escalated to senior management.
11. Transport in the designated centre currently being reviewed. Booking system to be implemented by 30th April 2022 should supports from a second transport be required. This will be discussed at the resident's house meetings to support activities.
12. PCP steering group remain in place to monitor the rollout of the person centred planning process.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	30/09/2022
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	30/09/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	31/07/2022

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	30/04/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/09/2022
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	31/12/2022
Regulation	The registered	Not Compliant	Orange	31/12/2022

23(1)(c)	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.			
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	21/04/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/04/2022
Regulation 28(2)(b)(i)	The registered provider shall	Substantially Compliant	Yellow	31/12/2022

	make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/12/2022
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	30/09/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes,	Substantially Compliant	Yellow	30/09/2022

	age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			