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:	Liscarra
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Announced
Date of inspection:	17 October 2023
Centre ID:	OSV-0007862
Fieldwork ID:	MON-0031690

About the designated centre

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

Liscarra consists of four bungalow type residences located on a campus setting on the outskirts of a city. Two of the bungalows can provide full-time residential care for seven residents each. The other two bungalows can support full-time residential care for four and two residents respectively with each of these bungalows subdivided into two apartments. Overall the centre has a maximum capacity of 13 residents over the age of 18 of both genders with intellectual disabilities. Each resident living in the bungalows has their own bedroom and other facilities throughout the centre include bathrooms, day/dining areas and kitchens amongst others. Residents are supported by the person in charge, nursing staff 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
Tuesday 17 October 2023	10:40hrs to 17:30hrs	Kerrie O'Halloran	Lead
Tuesday 17 October 2023	10:40hrs to 17:30hrs	Lucia Power	Support

What residents told us and what inspectors observed

This was an announced inspection, completed to inform the decision making with regard to the renewal of the centre's registration. Liscara is one of the designated centres that comprises of four bungalow houses which is based on the campus of Bawnmore. Thirthteen residents were living in the designated centre at the time on the inspection. Each bungalow in Liscara has a different internal layout, with some bungalows sub-divided to contain apartments. On the day of the inspection the inspector visited each bungalow, however one apartment was not visited as requested by the resident, and this was respected by the inspector.

On arrival to the centre the inspectors were greeted by members of the provider's management team, where an introductory meeting took place. Shortly after this the inspector spoke to the person in charge of the designated centre. An inspector visited all four bungalows and had the opportunity to meet eleven residents, along with a number of staff on duty supporting the residents on the day of the inspection. One of the residents had a planned hospital appointment on the day of the inspection, and as mentioned another resident requested not to meet the inspector. Residents who chose to engage with the inspector spoke about how they enjoyed living in their home and the activities they complete and enjoy on a daily bases as well as some goals which had been achieved. Staff spoke to the inspector about the support they receive from the person in charge and senior management of the centre in their roles to activity engage residents in the community and in activities of their choice. This was seen clearly seen on the day of the inspection with pictures displayed and both residents and staff telling the inspector about the activities they had completed and were involved in.

On arrival to the first house, the inspector was greeted by the staff member and shortly after by three residents who were present. One resident left shortly after the inspector's arrival to attend an activity in a day service located on the campus. Two other residents were present with one resident enjoying table top activities with a staff member, another resident remained in bed as per their wishes. The inspector spoke to the resident who appeared to be enjoying their activity. The staff member told the inspector they would be going out for a drive soon and the resident had chosen this activity and would choose where to go. The house was noted to be homely and welcoming, with the residents' pictures on display and bedrooms decorated as per the residents' wishes with their preferred items.

In the second house the inspector met with three residents living there. One resident was preparing to go for a walk on campus to visit and say hello to residents in other houses, an activity they enjoyed daily. Two other residents were in the dining/ living room relaxing watching some television. Both appeared relaxed and comfortable. One resident spoke with the inspector about activities they enjoy and how they had been to a sporting event which they really enjoyed. They were also very excited about the construction works of another centre on the campus coming to completion as an opening party would be held with music and dancing. The

resident was very proud of their achievements and the activities they took part in. The staff spoke about activities the residents enjoyed such as pet therapy, music therapy, horse riding and equine therapy, as well as visiting the local barber, cafes and shops in the community regularly.

The inspector visited the third house, which was sub-divided into a three bed bungalow and a one-bedroom apartment. On arrival the staff was preparing dinner for the residents in the bungalow. The inspector briefly spoke to the staff member and greeted and residents. A picture display of activities was available to residents for their daily activities. The inspector next visited the apartment and was warmly greeted by the resident living here. The resident was being supported by staff in the house and told the inspector they would be heading out later in the afternoon. The staff spoke about the activities the resident enjoys, such as drives in the community and going to local cafes. The resident's home was seen to be decorated with their personal items. During the inspectors time here they had a visitor from an assistive technology personal who was seen to sign into the visitor's book of the centre and greet the resident.

The inspector then visited the final bungalow which comprised of two apartments. As mentioned previously, one of the residents here had requested the inspector not to visit them, this was respected by the inspector. The inspector visited the resident in the other apartment, they were greeted by the staff and introduced to the resident who was watching a movie in their sitting room. The staff showed the inspector a picture display of the resident's goals they had in place in the residents sitting room, as this was more meaningful to the resident. The staff explained that the easy-to-read document available for resident to identify their goals was not meaningful for this resident, therefore it was adapted to the picture display. When the staff discussed the resident's goals and indicated to the pictures on the wall the resident engaged positively with this.

Staff spoken to on the day of the inspection had worked in the service for a number of years and it was evident that they were very knowledgeable of the care and support needs of each resident. Inspectors observed positive interactions between staff and the residents in which staff spoke and communicated with residents as per the residents assessed needs and in a caring and respectful manner at all times. Staff ensured to support and promote the rights of the residents in regular residents meetings, easy-to-read documents and finding alternative methods to ensure the residents were kept informed about their lives, for example adapting resident's goals to a picture format to support them.

The residents were supported by staff or a family member to complete the Health Information and Quality Authority (HIQA) pre-inspection questionnaires, all of which were viewed by the inspector. Such questionnaires covered topics like residents' bedrooms, food, visitors, rights, activities, staff and complaints. In these, activities which were listed as being undertaken by residents included going for a walks in the community and on the campus grounds, going to the barber, visiting friends, going for meals out, bingo, cinema, overnight trips, concerts and swimming. The inspector observed some these activities displayed in picture format on an activity schedule for the centre for the residents daily activities. The residents' questionnaires

contained positive responses for all topics and family complimented support and care received in the centre and the communication supports in place the centre.

Overall the inspectors found that Liscara provided person-centred care and support. Residents appeared comfortable and content in their homes and the support they were receiving. Some areas for improvement are required in relation to governance and management, premises, fire precautions,individual assessment and personal plans, medication management and residents' rights. this will be discussed in the next two section of the report.

The next two sections of the report present the finding of the inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Bawnmore campus is made up of five centres, with each centre having an additional condition pertaining to fire and premises. Liscara additional condition is that the provider shall address the regulatory non compliance's as outlined in the plan dated 21 September 2020 to the satisfaction of the Office of the Chief Inspector no later than 5 January 2024.

Premises and fire precautions continued to be not complaint 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 providers overall plan for the campus related to a high level decongregation plan for Bawnmore with details pertaining to each individual centre. On the day of inspection the provider gave an update in relation to the project plan and also gave the inspectors a detailed plan of progress to date. It was evident that the provider was keeping as much as possible to these time lines and demonstrated oversight and commitment to this project plan.

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

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 PICs 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 providers business address. Clarity was sough in relation to the resident's choice of banking and if consent was given and if residents were afforded a preference of whom to bank with. The provider did not have any evidence to support that the residents were involved to select a bank of their choosing, were consulted and had the freedom to exercise control in relation to this. This will be discussed further under 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 PIC on a monthly basis reviewed all incidents and ensured there was follow up where required.

Improvements were required in relation to records regulation 21. A sample of staff files were reviewed for staff employed the provider had records in place as per schedule 2. However there was not a clear process for people working in the centre who were on a community employment scheme CE. The only supporting documentation was Garda Vetting and a training record. The statement of purpose included CE workers as part of the staffing compliment within the statement of purpose and they carried out the same functions as some of the staff. There was no list of duties, no evidence of an induction and no evidence of the records as per schedule 2. On the day of inspection the provider agreed to ensure that the same process would be in place as for staff employed by the provider.

The inspector reviewed the staffing arrangements and found that they ensured residents were supported by staff with the appropriate skills and experience. The staff complement was consistent with the staff numbers outlined in the registered providers' statement of purpose. There was a regular and familiar staff team in

place that ensured the continuity of care for the residents. Staff numbers allocated allowed for individual and personalised supports and care. There was a planned and actual roster maintained that accurately reflected staffing arrangements in the centre. Staff spoken with had an excellent knowledge of the care and support for the residents and were very person centred in their approach.

The inspector reviewed the staff training matrix and saw that all staff mandatory training was up-to-date. When required, refresher training was available to staff and clearly identified on the staff training matrix in place. Staff had completed training in fire safety and safeguarding, as well as completing training to support the residents as per their assessed needs such as manual handling and positive behaviour support awareness.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Registration Regulation 5: Application for registration or renewal of registration

As required by the regulations the provider had submitted an appropriate application to renew the registration of the centre along with the required prescribed documents.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a full-time, suitably qualified and experienced person in charge to the centre. On review of relevant documentation there was evidence the person in charge was competent, with appropriate qualifications and skills to oversee the centre and meet its stated purpose, aims and objectives. The person in charge demonstrated good understanding and knowledge about the requirements of the Health Act 2007, regulations and standards. The person in charge was familiar with the residents' needs and could clearly articulate individual health and social care needs on the day of the inspection.

Judgment: Compliant

Regulation 15: Staffing

There was an actual and planned roster in place and this was maintained by the

person in charge. From a review of the rosters, the inspector saw that these were an accurate reflection of the staffing arrangements in place for the centre.

The inspector observed that there were adequate staffing levels in place in order to meet the needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training, including refresher training when required. A range of training courses had been completed by staff to ensure they had the skills to support the residents as per their assessed needs. A schedule of training for 2023 was also in place. At the time of the inspection, the provider was reviewing arrangements for human rights training. Arrangements were in place for staff to take part in formal supervision.

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 the inspectors to review. Improvements were required with this regulation. A sample of staff files were reviewed for staff employed the provider had records in place as per schedule 2. However there was not a clear process for people working in the centre who were on a community employment scheme CE. The only supporting documentation was Garda Vetting and a training record. The statement of purpose included CE workers as part of the staffing compliment within the statement of purpose and they carried out the same functions as some of the staff. On the day of inspection the provider agreed to ensure that the same process would be in place as for staff employed by the provider.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had ensured that the designated centre was adequately insured and had provided a copy of the up-to-date insurance document as part of the registration renewal.

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. There were arrangements in place to monitor the quality of care and support in the centre. The person in charge carried out various audits in the centre on key areas relating to the quality and safety of the care provided to residents. The provider had ensured six-monthly unannounced visits to the centre were completed as required by the regulations. Where areas for improvement were identified within these audits, plans were put in place to address these. Additionally, the provider had ensured that the annual review had been completed for the previous year.

Liscara has an additional registration condition 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 Office of the Chief Inspector no later than 5 January 2024. The provider has had delays in meeting this condition and has had extensive regulatory engagement between HIQA and the provider since 2021. As the provider has had significant delays in progress with an overall fire safety plan and meeting the requirements of the of the condition by January 2024, HIQA was not assured that this would be met.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose and function for the designated centre. This is an important governance document that details the care and support in place and the services to be provided to the residents in the centre. Some aspects of this required review in relation to the governance arrangements for night time staffing and to review the floor plans to ensure they were an accurate reflection of the existing premises. This was required to be updated and reviewed by the provider and re-submitted to the chief inspector.

Judgment: Compliant

Quality and safety

As discussed in the last section of the report the provider had good systems in place to ensure oversight of the running of the centre. As per the centres previous inspections, the bungalows visited were seen to be well-furnished and homely, but continued not to contain sufficient fire containment measures. As mentioned earlier in the report the provider has a high level decongregation submitted to the Chief Inspector which will address the issues outstanding in relation to fire compliance of the residents current homes.

Each resident had an individual personal plan in place. Such plans are required by the regulations and are intended to provide guidance for staff in meeting the assessed needs of the residents. The inspector reviewed a sample of these plans and overall noted that they contained a good level of information on how to support the residents. A person-centred planning process was in place to ensure that residents and their families were involved in the review of such plans. During this process goals for residents were identified. Residents had goals on accessing a local restaurants for meals out, starting new activities such as reflexology and going on day trips as well as planning overnight holidays. However, some improvement was required in the area of ongoing recording of resident's goals. From the documentation reviewed on the day of the inspection it was seen that residents had goals identified, however inconsistencies for some residents were present in recording actions, progress and time lines for residents to achieve these goals.

Residents had access to opportunities and facilities while in the centre. They had opportunities to participate in a variety of activities in the local community based on their interests and preferences. The inspector observed on the day of inspection the individual day programmes each resident accessed in line with their wishes.

Residents' safety was promoted in the centre. All staff had received training in safeguarding vulnerable adults from abuse. Staff were informed on the steps to be taken if a safeguarding concern should arise in the centre or in the residents' life. The contact details were on display in the centre for the complaints and safeguarding officer. Safeguarding was included as an agenda item at the residents' house meetings and team meetings. Each resident had access to a behavioural therapist, and a behaviour support plan for those residents that required this support. These were reviewed by the inspector and seen to be reviewed regularly with input from the person in charge and staff team. Staff were aware of resident's behaviour support plans in place.

The inspector viewed the contents of the medicine storage press. It was seen that arrangements were in place to keep this storage secure and it was found to be clean and tidy. The person in charge had ensured a clear system is in place for the receipt and administration of medications. A sample of the medicine records were reviewed which were found to be of a good standard. However, some improvement was required. For example, in one bungalow two medications were seen to be out of date, liquid medications not clearly labelled with opening date and expiry date not visible on all medications.

Resident's rights were promoted by the care and support provided in the centre. Residents could access advocacy services if they wished to avail of it. Easy-to-read

documents were available to residents, such as a complaints procedure. Residents' personal plans included clear detail on how to support individual residents with their personal, social and intimate care needs which ensured that the dignity of each resident was promoted. However, on a review of the sample of residents' personal plans reviewed it was seen that some residents had sleep charts in place. This meant staff were carrying out the practice of checks every hour throughout the night. There was no clear rational documented on the resident's personal plan. For example, a residents night time plan in place outlined how the resident can suffer from insomnia. However, the residents door was documented to be kept open and night time checks hourly were being completed. There was no evidence that the resident had been consulted about this practice, or had clear rational for the checks in place. The inspector spoke to staff in the centre and outlined it had been an ongoing practice. The impact of these checks had not been considered by the provider and there was no assessed need or risk identified to support this practice in the residents' individual personal care plans. This practice compromised the privacy of residents many of whom required little or no support during the night.

Regulation 13: General welfare and development

Residents were found to be provided with opportunities for leisure and recreation in line with their wishes, interests and needs. Residents had the opportunity to attend a day service or par-take in different classes of their choosing in the day service hub located on campus. One resident spoke about the horse riding they attend weekly that they really enjoy, as well as visiting the local pub.

Residents reported they enjoyed a range of activities of choice, such as going to the cinema, attending concerts, going on holidays and day trips to various amenities of their choice. In addition, residents had opportunities for leisure and recreation in their home such as doing art work, baking, gardening, listening to music and watching television.

Judgment: Compliant

Regulation 17: Premises

The premises visited on the day of the inspection in some areas remained of poor standard and in need of maintenance. While the provider had made an effort in making the bungalows more homely, they were seen to be well-furnished and residents had their personal items displayed. Storage in some bungalows required attention, as items were stored on the floor.

Judgment: Not compliant

Regulation 28: Fire precautions

There was inadequate fire containment measures in four of the bungalows which comprise of this designated centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had systems in place for the ordering, receipt, prescribing and administration of medicines. Staff were knowledgeable on medicine management procedures, and on the reasons medicines were prescribed. Medicine and administration records were complete in line with requirements. Medicines were securely stored in a locked press.

Some improvement was required to ensure safe practices were in place relating to medicine management. For example, some medication were seen to be out of date, liquid medications not clearly labelled with opening date and expiry date not visible on all medications.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that a comprehensive assessment of the health, personal and social care needs was completed for each resident. The personal plans were also subject to regular review and reflective of individual and person-centred care. The provider ensured that the designed centre was adapted to meet the needs of the residents, with an assistive technology personal seen to visit the centre and adapt the environment to meet the needs of the residents.

However, some improvement was required in the area of ongoing recording of resident's goals. From the documentation reviewed on the day of the inspection it was seen that residents had goals identified, however inconsistencies were present in recording actions, progress and time lines for residents to achieve these goals.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were protected through staff training, the ongoing review of incidents and discussions at team meetings and residents' meetings about safeguarding. Where concerns of a safeguarding nature arose, these were found to be responded to and reported to the designated officer.

Residents had access to easy-to-read information about safeguarding and abuse. Residents had imitate care plans and personal care plans in place, which detailed the supports required in this area. Residents spoken with said they felt safe in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted about the running of the centre through regular residents' meetings where information about the centre was shared and choices about their day-to-day lives were discussed. Residents met with during the inspection enjoyed a range of activities that were individual to them and their personal preferences with regard to their interests. For example, residents had been supported to attend mass if they wished or they could access on television or radio. the residents were seen to be treated with dignity and respect by the staff supporting them. Staff used a variety of communication supports in line with the residents individual needs and preferences.

However, some improvement was required in relation to residents' rights with regard to their finances and nightly checks.

The provider did not have evidence documented in place for all residents for the practice of checking residents throughout the night. Where some residents were being checked throughout the night this had not been reviewed as a restrictive practice and therefore the impact of this practice on the rights of residents was not considered.

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

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	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 Liscarra OSV-0007862

Inspection ID: MON-0031690

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 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 Liscarra to come into compliance will be rolled out and completed by Q1 2026 as part of the Bawnmore plan agreed with HIQA. • Three residents will transfer from Cedar 8 to a house in the community in Ardnacrusha. The other resident will transfer internally within Bawnmore. This will result in Cedar 8 closing. • One resident will transfer from Cedar 10 to a community house in Doon. This house has been purchased and will be upgraded during 2024. The other resident will transfer within Bawnmore. • One resident will transfer from Cedar 9 to the same community house in Doon. • Two residents will transfer from Cedar 9 to a fire compliant bungalow in Bawnmore. • Four residents will transfer from Cedar 7 to a community house in Pallasgreen by Q1 2026 and Cedar 7 will close. This revised date for Pallasgreen was confirmed by HSE on	

9th November 2023.
• 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.
• Risk assessments in place for unstaffed houses by night and reviewed quarterly.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A timeline for Liscarra to come into compliance will be rolled out and completed by Q1 2026 as part of the decongregation plan and Fire upgrade, which will provide high quality homes for residents.
• 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.
• The PIC met with the facilities manager on the 07.11.2023.
• Shelves constructed in storage room in Cedar Drive 9 on the 14-11-2023 to store items off floor.
• Walkabout scheduled with the assistant facilities manager for the 22-11-2023 to identify any works required to update the premises.

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 Liscarra to come into compliance will be rolled out and completed by Q1 2026 as part of the Bawnmore plan agreed with HIQA.
• Three residents will transfer from Cedar 8 to a house in the community in Ardnacrusha. The other resident will transfer internally within Bawnmore. This will result in Cedar 8 closing.
• One resident will transfer from Cedar 10 to a community house in Doon. This house has been purchased and will be upgraded during 2024. The other resident will transfer within Bawnmore.
• One resident will transfer from Cedar 9 to the same community house in Doon.
• Two residents will transfer from Cedar 9 to a fire compliant bungalow in Bawnmore.
• Four residents will transfer from Cedar 7 to a community house in Pallasgreen by Q1 2026 and Cedar 7 will close. This revised date for Pallasgreen was confirmed by HSE on 9th November 2023.
• 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.

• Risk assessments in place for unstaffed houses by night and reviewed quarterly.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

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

Regulation 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 & 15.11.2023.
• 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 and CNM1 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:
• Restrictive practice meeting will take place 5th December in relation to residents being checked at night.
• All night routines sleep charts and the rational of checking residents by night will be reviewed.
• Restrictive practices will be put in place where required and documentation completed as part of the restrictive practice procedure.
• Risk assessments and night protocols in place for all houses in Liscarra.
• Assistive technology in place in all houses to alert staff if a person supported requires

support by night.
• Restrictive Practices in place for the assistive technology, these are reviewed each quarter in conjunction with the MDT.
• 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 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 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	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 inspection by the chief inspector.	Substantially Compliant	Yellow	31/01/2024
Regulation 23(1)(a)	The registered provider shall ensure that the	Not Compliant	Orange	31/03/2026

	designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	Substantially Compliant	Yellow	31/01/2024

	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.			
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