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:	Short Notice Announced
Date of inspection:	21 October 2020
Centre ID:	OSV-0004779
Fieldwork ID:	MON-0029982

About the designated centre

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

The provider described the centre as one which 'is committed to providing person centred and person directed service that support life choices of service users.' East Limerick Services provides a full-time residential service. Accommodation is in four single-storey houses. Each house has a sitting room, kitchen, single occupancy bedrooms, modified sanitary facilities and laundry facilities. Three houses are grouped together and the fourth house is approximately 16 kilometers away. All houses are on the outskirts of two rural towns in Limerick. Between three and five residents live in each house. There are staff working in the centre at all times. The service is available to both male and female adults with a diagnosis of an intellectual disability.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 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 21 October 2020	10:30hrs to 19:00hrs	Lucia Power	Lead
Wednesday 21 October 2020	10:30hrs to 19:00hrs	Aoife Healy	Support

What residents told us and what inspectors observed

Due to COVID-19, the inspectors restricted their movement in the centre and therefore were unable to spend more time with the residents. However, the inspectors visited three of the houses in the centre at a time that was suitable for residents. In total the inspectors got to meet nine residents in their home. It was observed that most of the residents were relaxing watching television or spending time with staff. Staff engaged well with residents and had a good understanding of residents' needs. Residents used different forms of communication from using words to gestures. Some of the residents expressed their views to the inspectors and were able to communicate how COVID-19 has impacted on their lives. One resident was upset that they could not attend day services and highlighted how they miss their friends and the activities. The inspector asked the person in charge if there was any support for the resident to connect with their friends via computer devices as this resident was very active on a virtual meeting with the inspectors in the previous two weeks. The person in charge told the inspectors that they had not used technology for this resident to connect with their friends from day services and that they would look into making this available.

Another resident said they would like to live in another house with one of their friends as they find noise difficult and that they had expressed this to staff, but nothing was happening. Another resident spent time in the day room as part of their routine, it was observed that they did not engage in any activity while in this day room. This was also noted on previous inspections.

Three of the residents had moved from their house in the community to another house in the complex which had three houses, all four houses made up this designated centre, this move had happened earlier in the year. The multi-disciplinary team had made this decision based on the needs of other residents. There was no evidence of consultation with the residents that moved and one family representative made a complaint that they were not happy with this move. At the time of inspection this complaint was not resolved or was there advocacy input for the residents affected by this move.

The three houses in this centre are within a community and within a short distance from the main shops. The inspectors asked about the residents access to the local community as it was noted in the activity logs that walks for residents are within the grounds of the centre an there was no evidence of residents been supported to go to the local shop. The person in charge advised that all shopping is done on line and that residents can request what they want and it is ordered through this process. From discussion with residents, discussion with the person in charge and from documentation reviewed it was evident that residents had limited access to their community and limited opportunities to develop and maintain personal relationships and links with the wider community. The practices noted on the day of inspection were institutional and based on a care model as opposed to rights based individualised approach. However, it was noted that staff interactions were kind and

unhurried and staff demonstrated a good understanding of each residents communication needs.

Capacity and capability

This short term announced inspection was a follow up to an inspection completed by the Health Information Quality Authority (HIQA) in January 2020. While there was some improvements since the last inspection there are still a number of areas that need to be addressed by the provider.

The provider had submitted an updated compliance plan to HIQA and this was discussed and reviewed with the person in charge so the inspectors could evidence the provider's responsibility to comply with the regulations. Of note the chief inspector was not adequately assured that actions on the compliance plan submitted based on the January 2020 inspection would result in compliance with the regulations.

These actions related to the following regulations, staffing, governance and management, general welfare and development, fire precautions, individual assessment and personal plan and residents rights. The findings in this inspection continued to find that the provider was not compliant in most of these areas with the exception of staffing which was substantially complaint. On the day of inspection an urgent action was issued in relation to fire precautions, this will be discussed under quality and safety.

At the previous inspection, staffing was not compliant and it was evident that the provider had made some improvements. The planned rotas reviewed matched with the actual rotas, showing staff on duty during the day and night. There was no agency staff in the last number of months and the provider had a relief panel to ensure consistency and familiarity of staff for the residents. The numbers of staff assigned to the centre were in line with the statement of purpose, however the skills mix was not, and the provider did not have the numbers of staff nurses and social care workers as identified in the statement of purpose. The person in charge verified that this was the case and it was noted that there was a recruitment campaign in July 2020.

The Person in charge ensured staff had access to appropriate training including refresher training, the inspectors reviewed the training logs and where refresher training was required the person in charge had identified dates for this training.

As part of the regulation 16 (training and staff development), the person in charge is to ensure staff are appropriately supervised, from discussion with the person in charge it was noted that not all staff have received supervision and it was not a regular practice within the centre. However, the person in charge showed the inspectors a schedule of supervisions which showed where some had taken place

and others were planned up to the end of 2020.

The inspectors reviewed the annual review that the provider carried out as per the regulation on the quality and safety of care and support in the designated centre. There was evidence of consultation with residents and representatives. The review focused on the actions from the HIQA inspection dated 08/01/20 and updates since this inspection. Some areas for improvement were noted in relation to representative's feedback such as: family not knowing the residents priorities in their person centred plans, individuals not being supported to attend an activity and the requirement to improve communication with families. It was also noted in the annual review that some families expressed that their family members' social and development needs were not being met. Where recommendations were made in the annual review there was no action plan evident as to how the provider would ensure improvements occurred. The findings in the annual review correlated with the inspectors' findings on the day of the inspection which will be discussed throughout this report.

The provider had a complaints procedure in place. The inspectors reviewed the complaints made in the centre and noted that records relating to a complaint made in March 2020 by a resident's representative did not demonstrate that they were informed of the outcome of their complaint. It was also noted that this complaint was closed, however on further review and discussion with the person in charge it was still ongoing. The person in charge told the inspectors that they would follow up with this complaint the following day.

Given the findings on this inspection and previous inspections the provider did not demonstrate effective governance and oversight to ensure the effective delivery of care and support and the quality and safety for residents.

Regulation 15: Staffing

Although the registered provider had ensured that the appropriate number of staff were engaged at the designated centre, the skill mix of staff engaged was not in accordance with the statement of purpose.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Although the person in charge had ensured that staff had access to appropriate training, including refresher training; however, arrangements were not place to ensure to provide appropriate supervision to all staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that there were management systems in place at the centre to effectively monitor and ensure consistent care and support to residents which was both safe and appropriate to their assessed needs. Furthermore, the registered provider had not ensured that effective arrangements were in place to support, develop and performance manage staff engaged at the centre .

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had in place a statement of purpose containing the information as set out in schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge ensure that notice was given in writing to the chief inspector within 3 working days of adverse events that happened in the centre.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a complaints procedure in place and complaints were investigated. However, the provider had not on one occasion informed a complainant of the outcome of their complaint, and documentation recorded the incorrect status of the complaint on the day of inspection.

Judgment: Substantially compliant

Quality and safety

The provider was committed to the care of residents in this centre, however the current practices were institutional in nature and this will be evidenced further on in the report.

The registered provider had appropriate health care plans in place for residents and these plans were very detailed and provided good guidance to staff. The health care plans took into account the health care needs of each resident and were reviewed in line with residents changing needs. The registered provider advocated for a resident when a a decision was made without the expressed wish of the resident been taking into account by a medical practitioner. A 'Do not attempt resuscitation' (DNAR) was put in place for a resident in January 2020 by the resident's general practitioner (GP), the person in charge along with a staff member did not agree with this as the resident was not involved in the consultation. They advocated to the GP that this resident should be involved in this decision and supports were put in place to explain to the resident who was able to express their views through communication aids that they did not agree with the DNAR, based on this consultation the GP removed the DNAR in line with the residents expressed wishes.

The person in charge ensured that staff had up-to-date knowledge and skills to respond to behaviours that challenge. Where behaviour support plans were required for residents it was evident that the senior clinical psychologist was involved and had oversight. The inspectors noted that support plans were reviewed on a regular basis in relation to residents needs and there was good communication and interaction to support staff understand these plans.

The inspectors reviewed a sample of resident's personal plans and although it was evidenced that the person in charge had linked with staff in relation to improving the quality of the plans, they still required improvement.The residents goals were not achieved within agreed timeframes. Also personal planning arrangements did not include consultation with residents or their representatives and the effectiveness of residents' personal plans were not subject to an annual review.

For example, some of the plans reviewed had no meeting date and the goals identified had a target date of November 2019. There was no evidence that plans were available to the resident in an accessible format and where appropriate to their representative. One of the goals focused on maintaining best possible health and the plan was to ensure that the residents' care plan was updated and reviewed and care plans are understood by staff. Another goal was to keep up relationship with family members, while another goal was to attend the sensory room. Having reviewed a sample of plans in place for residents it was evident that goals were not reviewed in line with the residents wishes and with appropriate consultation with the resident or where required their representative. Of note the provider in their annual review had captured feedback from family members and their concern was that while they were aware of the person centred planning process they were not aware

of the residents' priorities.

Regulation 5 states that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances. Based on the findings on this inspection, the residents' plans were not updated in line with this regulation and the provider's own planning cycle stated that a full planning cycle is 13–14 months, which exceeded the annual time frame cited in the regulation.

The provider committed after the previous inspection to reviewing the individualised weekly timetable for all residents. These timetables were in place on the day of inspection. The inspectors reviewed a sample of five residents timetables and it was noted that there was limited opportunities for residents. Resident's daily activities were repetitive and institutional in nature, with little evidence of activities outside of the centre's grounds. For example, a review of one resident's weekly plan showed no activities outside of the centre and revolved around walks in the grounds, watching TV and sleeping. When asked if residents were supported to access the nearby local shops, the person in charge stated this option had not been explored to date

As noted previously in this report all grocery shopping is done on line and the residents' expressed what they want from the shop. The provider had not afforded the residents opportunities to develop their skills and maintain relationships in their community. It was evident from meeting some of the residents that they would enjoy these opportunities and it would promote their independence. In the provider's annual review it was captured that family members felt their family members' social and development needs were not been met.

Fire precautions were not compliant on the previous inspection and the inspectors were aware that three of the four houses in this registered centre was complaint with the installation of fire doors to contain an outbreak of fire. On the day of inspection, the inspectors were told by the person in charge that one of the house still required fire doors and there was no action in relation to these outstanding works. The inspectors reviewed the fire drills that were carried out in the centre and noted that these drills were conducted when there was maximum staff in place, there was no evidence that a simulated fire drill was carried out to assess the effectiveness of fire arrangements when only minimal staffing was present such as at night-time. It was noted on one of the fire drills reviewed, that a resident refused to leave the premises during the fire drill. There was no evidence of training records or learning to support this resident, but reference was noted in the residents personal evacuation egress plan (PEEP), it was noted in this plan that two staff would carry out the documented strategies. However given that there is only staff per house per night in the three of these houses it would not be possible to implement these strategies based on the needs of the residents and the staffing levels in each house.

An urgent action was issued on the day of inspection requesting the provider to demonstrate that they have effective fire management systems in place, under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did not provide assurance that the risk was

adequately addressed

The provider had up-to-date guidance in relation to infection control and had contingency plans in place for COVID-19. It was evident throughout the inspection that all staff adhered to the protocol in place and the person in charge ensured there was adherence in place to mitigate the risk of infection.

Regulation 13: General welfare and development

The registered provider did not demonstrate that residents were provided with appropriate support in accordance with evidence based practice, having regard to the nature and extent of the residents disability and assessed needs and their wishes. There was limited opportunities for residents to develop and maintain personal relationships and links in the wider community.

Judgment: Not compliant

Regulation 17: Premises

The registered provider ensured that the premises were kept in good state of repair and were clean and suitably decorated.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider ensured that residents who may be at risk of a healthcare associated infected were protected by adopting procedures consistent with the standards for the prevention and control of healthcare infections published by the authority. The registered provider also ensured that the guidance in relation to COVID-19 was up-to-date and in line with the health protection surveillance centre.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider did not ensure that effective fire safety management systems were in place and that effective measures were in place to evacuate residents in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge did not ensure that the personal plan is subject to a review, carried out annually of more frequently and conducted in a manner that ensured the maximum participation of residents. . The person in charge did not ensure that personal plans were made available to residents in accessible format.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had appropriate healthcare plans in place for each resident and access to medical treatment if required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge ensured that staff had up-to-date knowledge and skills appropriate to their role, to respond to behaviour that is challenging and to support residents manage their behaviour.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider did not ensure that residents in accordance with their wishes participates in, and consents, with supports where necessary, to decisions about his or her care and support, have freedom to exercise choice and control in their daily life. There was no evidence on the day of inspection to demonstrate that residents were consulted about a move to another house or had access to advocacy

services.
Judgment: Not 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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for East Limerick Services OSV-0004779

Inspection ID: MON-0029982

Date of inspection: 21/10/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Statement of Purpose will be amended to reflect the skill mix on the floor which is identified as meeting the needs of residents.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Formal support and supervision was temporarily suspended across the BOCSI during the first number of months of COVID 19 due to requirement to minimize foot fall and capacity issues in terms of time required for formal 1:1 supervision in the context of a pandemic. • The PIC had arranged for 1:1 support and supervision for a number of staff who have required or requested same. This will continue to be facilitated. • Supervision takes place via staff meetings on a weekly basis (Teams). The PIC uses these meetings as an opportunity for staff to raise any concerns they have and the PIC will subsequently follow up on any issues identified with the staff member. • The PIC ensures that minutes of staff meetings are circulated to all work locations and they are readily available for any staff who are not in attendance at the meeting. • The PIC's office is located on the premises of 3 houses in the Designated Centre and the PIC is available to provide on the spot supervision as required. • In terms of the 4th house in the Designated Centre the PIC receives daily e-mail updates and has regular phone contact to ensure support and supervision of staff. • There is a plan in place to ensure that each staff member will receive one face to face	

support and supervision on a 1:1 basis before the end of 2020.
• A timetable of support and supervision will be put in place for 2021 to ensure that each staff member receives support and supervision in line with the BOCSILR policy. Dates for support and supervision for all staff for the 1st quarter of 2021 are currently being scheduled.
• Leadership training will be rolled out within the BOCSILR during 2021. This training had been scheduled to take place during 2020 but was put on pause as a result of the pandemic. The PIC and the CNM1s of this designated centre will be prioritized for this training.
• The National Quality Team of BOCSI are finalizing a national person centre planning training programme, in line with the Council of Quality Leadership tool of personal outcomes. This training programme will be finalized on 13th January 2021.
• The management team will attend the programme as a priority.
• Following this management training the PCP training will be rolled out to all staff in East Limerick designated centre.
• Training will be completed by the end of the 1st quarter in 2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• There is a currently a vacant Senior post within Integrated services which has resulted in a gap in the governance structure for this designated centre.
• As per HSE procedure, a business case has been submitted to the HSE for approval to recruit this post on 9th November 2020. The HSE Business Manager for disability has formally given her support for this approval. As soon as formal approval is issued from the office of the Chief Officer a recruitment campaign will take place as a priority.
• This post will directly support the Person in Charge of East Limerick designated centre and this centre will be grouped with other designated centres within the Integrated service management structure to facilitate shared learning and formal peer support.
• The PIC will attend a number of executive coaching sessions to support her in the role of PIC in the interim. These sessions will commence in December.
• Management in this designated centre will attend Leadership development training - currently being reviewed by National Training Function of the BOCSI. Programme to be tendered and rolled out during 2021
• Following consultation with Senior Management, members of Multdisciplinary team and National Head of Quality and a project team will be set up to support management and staff in respect of further improvements in the delivery of support to the individuals living in the East Limerick designated centre. The project team will have a clear purpose and timeline and will report to members of the Senior Management team on a monthly basis.
• The management team will attend a two-day Person Centred Planning training course due to be rolled out across the services in 2021. The training is set up so that it aligns to the values and ethos of the BOCSILR as well as to that of CQL (Counsel on Quality

and Leadership).
• Following this management training the PCP training will be rolled out to all staff in East Limerick designated centre.
• The annual review for 2020 will be completed in Q1 2021. The annual review template includes space to document actions to be taken in response to feedback from residents, feedback from families and review of records.
• Support and Supervision will be scheduled for all staff by year end and support and supervision will be scheduled for all staff for Q1 2021.
• Complaints will be reviewed by the PIC on a monthly basis to ensure the status of complaints is monitored.
• A governance plan for this designated centre will be submitted to HIQA by 30th November 2020.
• The business case for one individual has been prioritized with the HSE. It was reviewed at the last business case meeting with the HSE on 10th November and escalated to the Head of Social Care o 20th November 2020.
• The regional advocacy group presented the situation pertaining to this business to the Head of Social Care, HSE as part of their recent engagement.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The organization has a complaints procedure in place which includes the requirement to outline if a complaint is resolved to the satisfaction of the complainant or if a complaint is escalated due to inability to resolve at local level.
• The PIC will ensure that all staff are aware of the complaints procedure and recording requirements.
• The PIC or delegate will review all point of contact complaint records on a monthly basis to ensure appropriate follow up.
• PIC followed up with complainant in respect of the status of his complaint on 09/11/20. Upon discussion with complainant, this complaint now remains open. The matter has been escalated to the Director of Services. The Director of Services has written to the complainant on 23rd November 2020 to confirm the status of the complaint.
• PIC has linked with 2 staff to give guidance on how to write a complaint from complainant's perspective and in a respectful manner. This was further discussed at staff meetings and staff advised to link with PIC/CNM when writing complaints for guidance and learning if required.
• Psychologist visits the centre on a weekly basis. This is another opportunity for the persons support to be heard by an external person and if they wish to make a complaint. It is also a support to staff.
• Complaints are discussed as part of staff meetings.
• Complaints will be reviewed on a monthly basis to ensure the status of complaints is monitored.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• The National Quality Team are finalizing a national person centre planning training programme, in line with the Council of Quality Leadership tool of personal outcomes. This training programme will be finalized on 13th January 2021.
• The Management Team of this designated centre will be prioritized for this training and will attend a two-day Person Centred Planning training course.
• Following this training the PCP training will be rolled out to all staff in East Limerick designated centre. The training is set up so that it aligns to the values and ethos of the BOCSILR as well as to that of CQL.
• An outcome of this training is that each person supported will have a new Person centred plan which would include at least one developmental priority and will promote connection to the community as well as meaningful activities.
• All keyworker's will be linked with a Clinical Nurse Manager so that they have a support mechanism for achieving the goals identified in the plan for the person they support. They are also supported to raise barriers to achieving a goal that actions can be taken to address any barrier.
• Members of the MDT including the Senior Psychologist, SLT and OT and Advocacy facilitator will support the management team in progressing this important work. In this regard a project team will be developed so that this support is coordinated, effective and results in improvement to the quality of life of the residents.
• All priorities identified will be presented to individuals in a format best suited to them (e.g.: easy read, video clip) and family members who are not in a positon to attend planning meetings will be given feedback by keyworker.
• Reviews of individual's plan will evidence feedback/input from individual.
• WIFI and use of a tablet is available in all houses. These tablets are being used by a number of residents to contact peers in other houses within the designated centre, link with family members via video link, attend regional advocacy meetings, engage in activities such as yoga and Tai Chi, watch concerts of favorite performers, watch mass, browse images of interest. This IT resource will be expanded to facilitate the reestablishment of links with peers from day service on a regular basis.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A single bed on wheels that can facilitate a bed evacuation in the event of a fire

whereby individual declines to leave will be installed by 30/11/20.
• The resident who sometimes refuses to evacuate his home during a fire drill is temporarily not living in the designated centre but will be supported to use this bed on his return.
• A wheelchair is now available in the home of this resident and can be used in the event that the individual declines to leave room and is not in bed.
• Incentive pack has been created and filled with items that individual enjoys/likes. This will be used as a positive reinforcement during regular fire drills to establish its effectiveness.
• Regular fire drills will continue to monitor the individual's response to the new fire drill protocol.
• MDT to be organized approximately 6 weeks after individual returns to residence to review effectiveness of recommendations.
• MAPA Hold has been deemed as not appropriate to use for individual.
• Individual's PEEP has been updated to reflect change in approach to evacuation.
• A simulated drill has taken place in respect of evacuation using the bed and this will be repeated when the resident returns to the designated centre.
• Risk assessments have been completed to support one staff supporting the fire drill coming from the adjacent house.
• The Facilities manager is scheduled to visit East Limerick to address maintenance issues arising as a result of this new evacuation plan that will further support the evacuation of the resident.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The National Quality Team are finalizing a national person centre planning training programme, in line with the Council of Quality Leadership tool of personal outcomes. This training programme will be finalized on 13th January 2021.
• The Management Team of this designated centre will be prioritized for this training and will attend a two-day Person Centred Planning training course.
• Following this training the PCP training will be rolled out to all staff in East Limerick designated centre.
• An outcome of this training is that each person supported would have a new Person centred plan which would include at least one developmental priority and will promote connection to the community as well as meaningful activities.
• The current plans will be reviewed by 31st December 2020 to ensure that the goals identified remain appropriate to the person and are being worked towards achieving for the individual.
• All keyworker's will be linked with a Clinical Nurse Manager so that they have a support mechanism for achieving the goals identified in the plan for the person they support. They are also supported to raise barriers to achieving a goal that actions can be taken to

address any barrier.
• Members of the MDT including the Senior Psychologist, SLT and OT, Advocacy officer will support the management team in progressing this important work. In this regard a project team will be developed so that this support is coordinated, effective and results in improvement to the quality of life of the residents.
• All priorities identified will be presented to individuals in a format best suited to them (e.g.: easy read, video clip) and family members who are not in a positon to attend planning meetings will be given feedback by keyworker.
• Reviews of individual's plan will evidence feedback/input from individual.
• WIFI and use of a tablet is available in all houses. These tablets are being used by a number of residents to contact peers in other houses within the designated centre, link with family members via video link, attend regional advocacy meetings, engage in activities such as yoga and Tai Chi, watch concerts of favorite performers, watch mass, browse images of interest. This IT resource will be expanded to facilitate tea club, reestablish links with peers from day service on a regular basis.
• SLT input will include improved communication supports for individuals. This will support staff in providing daily opportunities of providing choice to individuals

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The residents in East Limerick Designated Centre are represented on the Regional Advocacy Council by one resident in the centre. This resident, along with staff support, attends regular zoom meetings for regional advocacy.
• A number of advocacy issues have been raised by the East Limerick Advocate since the start of COVID 19 including access to day services and access to community based activities in the context of COVID 19.
• In terms of access to day services this issue has been raised by the Regional Advocacy Council with the Direct of Services as well as in a recent engagement with the funder. Advocates have been advised by the funder that a return to day services for residents is not envisioned at this time in the context of COVID 19. This issue remains on the advocacy agenda.
• In terms of access to community based activities a risk assessment process was introduced by the services in July 2020 to support residents to access the community in as safe a way as possible in the context of COVID 19 and public health guidance. Several residents in East Limerick have been supported to participate in preferred activities in the community through the risk assessment process. Activities include: attending weekly mass, hairdresser, visit home, chiropody service, attending funeral/months mine, attending non hospital appointment e.g.; spec savers. Much of these activities are on hold since level 5 restrictions were implemented.
• PIC will ensure that risk assessments are reviewed depending on the level of restrictions in order to ensure optimum activities in line with public health guidance e.g. resident was recently supported to visit the local church in the absence of Sunday Mass.
• Four residents moved house at the start of COVID 19 due to the requirements of

lockdown and the care and support requirements of one resident which were having a significant and ongoing impact on all peers. This impact had been identified at the previous HIQA inspection of this designated centre. This resident requires his own living environment and the existing arrangements would have been exacerbated in a lock down situation. Due to the unprecedented circumstances the decision was taken under the guidance of the MDT and residents were not consulted in advance given the urgency of the move and the capacity of the residents. The decision was made in the best interest of all residents.

• While residents involved in these moves do not have the capacity to self-advocate there has been ongoing engagement with their families.

• In the absence of a formal assisted decision making structure at this time engagement with families regarding future decision making has been identified as the most appropriate way to support advocacy for these residents. The MDT completed a Questionnaire that was developed for each resident looking at the positives and negative impacts of the move on the residents. This included any changes in their physical, emotional and mental health since the move. Each staff member who supported the gentlemen prior to the move and since the move where all given an opportunity to complete the questionnaire. The information was analyzed and a report was completed for each person supported. This report was provided to each family in order to aid them to reach a decision which they believe is in the best interest of their family members. The outcome of this review, which recommended that the current arrangement is better for the residents was discussed with the families. Two of the families have expressed their wish for their family member to be supported to return to their home in due course.

• Following the Inspection, the PIC has contacted the National Advocacy Council with a view to sourcing an independent advocate for each of the residents. The families have been informed of this engagement.

• Current SLT input/feedback and training will support staff to provide opportunities to allow individuals to make choices in their daily lives. This input will be included in PCP process and communication supports will be updated in line with this feedback to ensure it is accessible to all staff/individuals.

• The Person supported who moved home at the start of pandemic is enjoying an enhanced quality of life, benefits of which have been noted in all aspects of his life and presentation. This is evidenced through regular MDT meetings and weekly person supported meetings and a reduction in the use of medication.

• The Director of Services continues to engage with the funder to secure funding to support the individual, who requires to live on his own, to do so in the future. The business case has been escalated to a senior manager on 20th November in order to progress.

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(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	30/06/2021
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	30/06/2021
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in	Not Compliant	Orange	30/06/2021

	accordance with their interests, capacities and developmental needs.			
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.	Not Compliant	Orange	31/03/2021
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	20/11/2020
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.	Substantially Compliant	Yellow	20/11/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2021
Regulation 23(1)(a)	The registered provider shall	Not Compliant	Orange	30/06/2021

	ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2021
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	30/06/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in	Not Compliant	Orange	31/12/2021

	place.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	11/12/2020
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	23/11/2020
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/06/2021
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant	Orange	30/06/2021
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out	Not Compliant	Orange	30/06/2021

	annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/06/2021
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in	Not Compliant	Orange	30/06/2021

	circumstances and new developments.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	30/06/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/06/2021
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights.	Not Compliant	Orange	30/06/2021
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in	Not Compliant	Orange	30/06/2021

	accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.			