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:	Lios Mor
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	03 July 2024
Centre ID:	OSV-0004745
Fieldwork ID:	MON-0042968

About the designated centre

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

Lios Mor consists of a large purpose built one storey building and a separate single occupancy one storey house located on the same grounds in a rural area but within short driving distances to some towns. The centre provides full-time residential support for up to 11 residents of both genders over the age of 18 with intellectual disabilities. Ten resident individual bedrooms are provided with four shared en suite bathrooms for eight of these bedrooms in the larger building. Other facilities available for residents in this building include a living room, day-dining room, a sitting room, a kitchen and bathrooms. The single occupancy house has one bedroom, a kitchen-living area and staff rooms. Support to residents is provided 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:	10

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 July 2024	06:25hrs to 15:30hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Most residents living in the centre at the time of inspection were met by the inspector. Some of these residents engaged verbally with the inspector but others did not. Staff were duty engaged pleasantly and respectfully with the residents.

This centre was made up of a large purpose built house for 10 residents and a single occupancy house located on the same grounds. At the time of this inspection 10 residents were living in the larger house while the single occupancy house was vacant. During previous inspections of this centre in 2023, it had been indicted that this single occupancy house was intended for a particular individual. On the current inspection the inspector was informed that this person would not be moving into the single occupancy house. A resident from another of the provider's designated centres was visiting the single occupancy house with a view to potentially moving in there.

When the inspector arrived to commence the inspection, all ten residents in the larger house were in bed at time with some staff going to help two of these residents to get up. During an initial walk around of this house the inspector noted that the doors of two bedrooms which were located beside one another were open. The inspector was informed that these were left open by the choice of the residents. Records later reviewed highlighted some instances where noise from one of these residents at night had woken the other. In some of these incidents the latter resident was upset by this, in others incidents no upset was recorded.

Also during the initial walk around the inspector observed what appeared to be a bowl of porridge left out on a table in the larger house's dining-day room. This bowl remained out until the first resident in this house had gotten up when they went to the dining-day room and ate from this bowl. Based on the inspector's observations, this bowl had been left out for at least one hour and five minutes before the resident came to it. When this was later queried with a staff member, it was suggested that contents of the bowl had been a different cereal, that it had been left out for as long it had been to soften it and that the resident liked their breakfast cold.

The inspector greeted this resident after they had finished their breakfast but the resident did not interact with the inspector. As the morning progressed, there was a changeover of staff and more residents were helped to get up and with personal care before being brought into the dining-day room for their breakfast. Staff on both shifts were observed and overheard to be very respectful and pleasant towards residents. For example, staff were seen knocking on residents' bedroom doors before entering while staff also warmly greeted residents when they came into the dining-room and asked how the residents were. At one point a resident was seen to jog in a hall with a staff member checking the resident to see if they were okay.

Such interactions contributed to the atmosphere in the house being relatively calm

and relaxed during the first hours of the inspection. Later the morning, while the inspector was having a discussion with the centre's person in charge, a resident could be heard vocalising while they were being supported in a bathroom by staff. It was highlighted by the person in charge that the resident could present in this way while in the bathroom which was also reflected in the resident's intimate personal care plan as read by the inspector. Similar vocalisations from this resident were heard later in the afternoon when the resident was again being supported by staff in the same bathroom.

This resident was met by the inspector in the larger house's dining-day room along with some other residents. One of these residents seemed happy when greeted by the inspector and was seen smiling. At the time this resident indicated to the inspector that they were having a nice cup of tea and were going to day services later. Another resident asked the inspector where he was from before telling the inspector where they were form. When asked by the inspector if they were doing anything later in the day, the resident shrugged. A third resident met at this time showed the inspector some items that they had with them in their handbag including some jewellery.

At one point during the day while the inspector was in a staff office with a member of staff, a resident entered and sat down in the office. The staff present engaged pleasantly with the resident during this time with the resident talking about meals and trips to a nearby town. When asked by the inspector if they ever went out for dinner, it was mentioned by the resident that sometimes they went out for a dinner to hotel. While still in the staff office, the resident was informed by another staff member that their dinner was ready. The resident left the staff office at this point appearing to be happy as they did so.

Two other residents were met by the inspector during the course of this inspection. Neither of these interacted verbally with the inspector but both were seen smiling with one of these shaking the inspector's hand. In total eight of the 10 residents present were met during on the day of inspection with five of the 10 residents leaving the centre during the day to attend day services operated in a nearby town by the provider. The other five residents remained in the centre for the inspection's duration. When reviewing notes of residents' meetings occurring in the centre, it was read that some residents raising issues around access to day services had been recorded in the complaints sections of the notes. Such matters though were generally not processed as complaints within the centre. This will be returned to later in this report.

Aside from this, the larger house of the centre was seen to be clean, well-presented and well-furnished on the day inspection. It had 10 bedrooms for individual residents, four of which were seen by the inspector and noted to be brightly decorated and personalised. Communal areas with within the larger house included a living room, a dining-day room and a smaller sitting room that could be used for residents to receive visitors in private if required. Bathroom facilities were also provided. These included some shared en suite bathrooms for bedrooms (en suites that could be accessed from two different bedrooms. The single occupancy house

was briefly visited during this inspection and was also seen to be well-presented.

It was observed though that the larger house that made up this centre required the use of a keypad to enter and exit the house via its front door. This had been acknowledged by the provider as being a restrictive practices and there were reasons for its use. However, at one point during the inspection, it was observed by the inspector that a postman who arrived at the centre to deliver some mail briefly entered the larger house by entering the code at the front door's key pad. It was subsequently queried by the inspector following the inspection if residents had been consulted about this. In response it was indicated that residents had been spoken with about this matter on 5 July 2024 and that those who were able to indicate a preference, indicated that they were happy for the postman to open the front door to deliver mail. No indication was given that residents had been consulted about this prior to the query raised by the inspector.

In summary, five of the 10 residents present during this inspection left the centre to attend day services while the other residents remained in the centre. While not all residents met engaged verbally with the inspector, some were seen smiling when met by the inspector. The residents' home was seen to be sell-presented on the day of inspection.

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

Capacity and capability

Particular oversight measures evidenced during the October 2023 inspection remained in place. Despite these, complaints raised by residents were not being processed as complaints while staffing provided was not always in keeping with residents' needs.

This centre had last been inspected by the Chief Inspector of Social Services in October 2023. Some regulatory actions were identified during that inspection related to residents' rights and safeguarding amongst other but there was evidence of increased oversight of the centre at particular times following concerns raised in this area during a May 2023 inspection. The provider submitted a satisfactory compliance plan response to the October 2023 and following that the centre had is registration renewed by the Chief Inspector until January 2027 with no restrictive conditions. When most recently applying to renew the centre's registration, the provider had sought to increase the capacity and footprint of the centre by adding a single occupancy house to the centre. As this renewal application had been granted the current inspection was specifically conducted within six months of this application taking effect to assess how the now larger centre was operating.

As referenced earlier in this report, the single occupancy house remained a vacant house at the time of inspection. As a result the same group of residents present during the two 2023 inspections remained in the centre. A change in needs for one of these residents had resulted in extra staff being approved for this certain at particular hours in recent months. However, it was noted that this additional staffing was not always in place. In addition, when reviewing residents' meeting notes the inspector noted some instances in 2024 where residents were referenced as complaining about staff shortages in centre. Despite this no complaints had been logged about such matters had been logged about these in the centre's complaints log. Actions around complaints had been identified during a provider six monthly unannounced visit in June 2024. The report of this visit as provided during the inspection process was found to be detailed but some of the content of the report resulted in further assurances being sought from the provider in the days following this inspection. Outside of this, the current inspection did find that measures for increased oversight of the centre at certain times as evidenced during the October 2023 inspection remained in place.

Regulation 15: Staffing

Staff rosters were being maintained in the centre but when reviewing rosters for June 2024 it was noted that the actual hours that some staff worked were not indicated on the rosters. The rosters reviewed indicated that minimum staffing levels day and night were in place in the centre generally. This included the provision of nursing staff on a 24 hour basis. The inspector was informed that since the previous inspection in October 2023 additional nursing staff had been recruited which helped provide for this. Three staff spoken with during the inspection raised no concerns about the staffing arrangements in the centre with one highlighting that on occasion, additional staffing support could be provided to facilitate appointments.

Despite this, when reviewing notes of residents' meetings that had taken place in 2024, it was read that there had been some occasions when residents had complained about staffing in the centre impacting their ability to leave the centre. This included the two most recent residents' meetings that had taken place in June 2024. The notes of one such meeting that had occurred four days before this inspection made reference to residents "complaining about staff shortages again". In addition, given a change in needs for one resident, additional staffing support for the centre between 8pm and 10pm had been approved in recent months. While the provider had altered shift patterns and was looking to recruit to ensure that these hours were filled, rosters reviewed indicated that the additional staffing support was not always in place for these hours. This, coupled with the notes of resident meetings reviewed, indicated that staffing in the centre was not always in line with residents' needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A training matrix provided included 28 different staff members with the matrix indicating that the majority of these staff had completed in-date training in areas such as fire safety and manual handling. However, some gaps were noted. For example, three staff had not completed training in personal protective equipment (PPE), three staff had not completed training in hand hygiene and three had not completed training in food safety. In addition to this, two staff were overdue refresher training in PPE, one staff were overdue food safety refresher training and three staff were overdue refresher training in basic living saving.

It was indicated to the inspector that staff supervision was to be done quarterly. While no individual staff supervision records were seen during the inspection, following the inspection communication was issued to the inspector from the person in charge indicating that all staff had received timely supervision during the first two quarters of 2024.

Judgment: Substantially compliant

Regulation 23: Governance and management

Measures to increase oversight of the centre at particular times as seen during the October 2023 inspection remained in place. These included;

- The person in charge altering their shift patterns to be present in the centre at different times.
- Members of management of the centre making three unannounced visits to the centre every month at varied times.
- Staff team meetings were taking place regularly at different times on the same day, with the person in charge present at all meetings, to ensure that staff from different shifts could attend.

During previous regulatory engagement concerning this centre, it had been suggested that the provider was giving some consideration to putting in place a clinical nurse manager (CNM) for night-time duty. While CNMs where available by day, on the current inspection it was indicated that the provider was not presently progressing with an additional CNM role for night-time time given the continued operation of the oversight measures outlined above.

Aside from these measures the provider was conducting key regulatory requirement which are intended to provide for oversight and to assess the quality and safety of care and support provided to residents. This included completing an annual review for 2023 which assessed the centre against relevant national standards. A report of this annual review was provided to the inspector and it was read that his annual review provided for consultation with residents and their representatives. Another

regulatory requirement is for the provider or a representative of the provider to conduct an unannounced visit at least once every six months to centre with such a visit to reflected in a written report.

Since the October 2023 inspection, two provider unannounced visit had occurred. The first had occurred on 22 November 2023 and the other on 18 June 2024. As this was a near seven month gap, this meant that the most recent provider unannounced visit had not been carried out in a timely manner. Some areas for improvement had been identified during the November 2023 unannounced visits with an action plan put in place assigning time frames and responsibilities to address these. When reviewing this action plan during the inspection, it was indicated that such actions had been addressed between December 2023 and May 2024.

However, in the report of the June 2024 unannounced visit, which was provided in the days after this inspection, it was read that there was a lack of evidence of follow up for the actions arising from the November 2023 provider unannounced visit. In addition, reference was made in the June 2024 provider unannounced visit around the accuracy of information that had been submitted as part of the provider's internal audit tracking. Such findings prompted the Chief Inspector to seek further assurances and information related to these findings and how the provider would ensure that actions plans were implemented.

In response it was indicated that the finding of the June 2024 provider unannounced visit were discussed internally within the provider who committed to conducting a review of the tracking system in the centre regarding information included in the provider's audit tracking. This would be monitored on a monthly basis with a quarterly update on this to be submitted to the provider's senior management. Where any issues identified could not be addressed locally, they would be escalated within the management structure. In the assurances submitted, the provider also committed to introducing a formal internal system of escalation if required for designated centres related to the findings of provider six monthly unannounced visits.

Such assurances from the provider were noted and it was acknowledged that the findings of the June 2024 provider unannounced visit were identified by the provider's own monitoring systems. Despite these, the findings of this inspection in Regulation 34: Complaints procedure and Regulation 29: Medicines and pharmaceutical services indicated that the management and monitoring systems in operation needed improvement to ensure that matters which impacted resident's quality and safety of care and support were promptly identified and addressed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The centre had a statement of purpose in place which is an important governance

document that describes the services to be provided in a centre and the supports to be delivered to residents while also forming the basis of a condition of registration. During the current inspection, it was found that the statement of purpose had been reviewed in March 2024 and contained required information such as the information in the centre's current registration certificate and details of the centre's organisational structure. The statement of purpose also contained details of the staffing arrangements for the centre in full-time equivalent (FTE). However, as mentioned under Regulation 15: Staffing, additional staff support for the centre had been approved for use in recent months. The FTE staffing details in the statement of purpose had not been updated to reflect this additional staffing.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The report of the June 2024 provider unannounced visit for the centre indicated that there had been no complaints since November 2023. Two areas for improvement were identified though during that visit related to complaints. These were ensure that all residents were aware of and supported to use the complaints procedure and also ensure that all staff are aware of where the complaints log was located. During the current inspection it was found that since the June 2024 provider unannounced two complaints from residents had been logged. These related to both residents being unable to attend day services. The complaints log indicated that the person in charge had spoken to both residents and the residents were happy following this.

Complaints was a topic that was discussed with residents during residents' meeting that took place in the centre. Notes were kept for such meetings with the inspector reviewing such notes for all residents' meetings that had taken place in 2024. When reviewing these the inspector noted that the section on complaints sometimes made reference to residents raising issues around access to day services before June 2024. While the inspector was informed that the provider was aware of such issues and it was being raised within the provider's internal advocacy, no complaints had been logged about this before the two recent complaints. In addition, as referenced under Regulation 15: Staffing, some resident meetings referenced instances where residents had complained about staffing in the centre while other resident meeting notes from March and April 2024 indicated that residents were raising issues about centre transport. None of these instances had been logged as complaints. This did not provide assurance that residents were aware of or assisted to understand the complaints procedures. It also indicated that complaints being raised were not entered into the centre's complaints log.

Judgment: Not compliant

Quality and safety

No regulatory actions related to safeguarding was found during this inspection. However, regulatory actions were identified around the use of a rescue PRN medicine (medicine only taken as the need arises) and health support plans. Access to day services away from the centre was being raised by some residents.

Residents had individualised personal plans in place which contained guidance on how to meet their needs. It was noted that there was some variance related to support plans for some residents' health needs while there had been some instances where a resident had not received a particular rescue PRN medicine as prescribed. Aside from health related issues, as referenced earlier in this report, some residents were raising issues around their access to day services although the provider was making efforts to address this. Such issues were referenced in residents' meetings that were usually held weekly. These were used to discuss topics such as infection prevention and control, menus and activities with residents although some meeting notes did reference medical appointments of individual residents being discussed during these communal meetings. Safeguarding was also discussed at such meetings. The current inspection did not identify any regulatory action under Regulation 8: Protection. This was an improvement from the two inspections of this centre in 2023.

Regulation 11: Visits

Logs reviewed for two residents indicated that they had received visitors to the centre while space was available within the centre for residents to received visitors in private away from their bedrooms if they wished to do so.

Judgment: Compliant

Regulation 13: General welfare and development

While it was indicated during the inspection that resident did get out from the centre with some attending day services and one resident telling the inspector about going to hotels for meals, based on the content of residents' meetings some residents were expressing a desire to attend day services more often. It was acknowledged that the provider was aware of this and it was highlighted during this inspection that efforts were being made to address this. In addition, it was indicated to the inspector that the two residents who were most often raising issues around day services had previously been availing of day services five days a week but were now availing of these for fewer days. While such matters were contributed to by staffing issues in the day services, which was not under the remit of the Chief Inspector, recent residents meeting notes had indicated that residents' ability to leave this

centre for outings or drives had been impacted by staffing issues. The issues around day services and the recent staffing issues raised impacted residents' abilities to participate in activities in accordance with their interests.

Judgment: Substantially compliant

Regulation 17: Premises

The premises provided for this centre was seen to clean, well-furnished and well-maintained. Since the October 2023 inspection it was observed that the flooring in a laundry room had been replaced. Sufficient communal space was available in the centre while residents had their own individual bedrooms. Four of these bedrooms were viewed by the inspector and seen to be brightly decorated and personalised.

Judgment: Compliant

Regulation 18: Food and nutrition

During a walk around at the start of this inspection the inspector observed what appeared to be a bowl of porridge left out on a table in the larger house's dining-day room. This bowl remained out for one hour and five minutes until a resident commenced eating from this bowl after getting up. When this was queried with a staff member shortly after, it was suggested that contents of the bowl had been a different cereal and that it had been left out to soften it. This staff also indicated that the resident liked their breakfast cold.

However, two other staff members spoken with by the inspector indicated that this resident had not expressed a preference as to whether they wanted their food hot or cold. It was further suggested that it had not been explored with the resident as to what their preference in this area was. One of these staff also informed the inspector that the resident had porridge for breakfast and that staff would try to give it hot to the resident. While this regulation was not reviewed in full during this inspection, taking into account the observations of the inspector and the inconsistent information provided by staff, this did not provide assurances around how the resident's breakfast had been served and if the resident's preferences had been fully considered in this area.

Judgment: Substantially compliant

Regulation 27: Protection against infection

As highlighted under Regulation 17: Premises, the centre was seen to be clean on the day of inspection. However, when reviewing records in the centre the inspector read a daily tasks sheet which set out specific tasks that were to be done every day during the day time and night time. Such tasks included cleaning. The inspector reviewed daily tasks sheets from 1 May 2024 on and noted 17 instances where either day time duties or night time duties were not recorded as being completed. This did not provide assurances that cleaning was being consistently conducted as scheduled.

Bottles of hand sanitiser were seen to be present in the centre on the day of inspection. It was noted though that one bottle had an expiry date indicated on it from November 2023. Other bottles did not have any expiry date indicated on them. As such the inspector could not tell if these had passed their expiry date or not.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

This regulation was not reviewed in full during this inspection but when reviewing documentation related to one resident it was noted that the resident was prescribed a rescue PRN medicine due to epilepsy. Such documentation indicated that the resident was receive this rescue PRN medicine at the onset of a seizure while the resident could also receive a second dose of this rescue PRN medicine if required. A protocol on the use of this rescue PRN medicine, from November 2023, indicted that the second dose was to be given 10 minutes after the first dose if the resident's seizure continued.

However, a separate epilepsy care plan for the resident, which had been reviewed in March 2024, indicated that the resident could get a second dose five minutes after the first if the seizure continued. Prescription records reviewed for the resident indicated that the resident was to receive a second dose 10 minutes after the first if required. As such the PRN protocol and the epilepsy care plan contained conflicting information on the use of the rescue PRN medicine. The same two documents were also noted to contain different information around when to call an ambulance in the event that the resident had a second seizure.

Records provided indicated that, outside of nursing staff, 17 of the 18 other staff who worked in this centre had completed training in the administration of this rescue PRN medicine which was stored in a staff office. A log of seizures experienced by the resident was being maintained. This log indicated that the rescue PRN medicine had been given but for two seizures, it was recorded in the log that the PRN rescue medicine had not been given at the onset of the seizure as prescribed. One of these instances indicated that the resident did not receive the rescue PRN medicine for three minutes.

Upon discussion with a staff member about this instance it was indicated that the resident had commenced a seizure in the presence of two staff with assistance called for from two other staff. One of these staff then retrieved the rescue PRN medicine from the staff office before administering it. According to the seizure log, the second instance involved the resident having a two minute seizure without being administered the PRN rescue medicine. Following the inspection it was indicated that the a staff responded to a vocalisation in the resident's bedroom and saw that the resident was having a seizure before getting the rescue PRN medicine while other staff supported the resident. When this staff returned the resident was coming out of the seizure so the PRN medicine was not given.

While such information was noted, the two instances as described highlighted that the resident had not received the PRN rescue medicine as prescribed. The storage of this PRN rescue in the staff office also reduced the potential to administer this at the onset of a seizure as staff would need to retrieve this from there in event that the resident commenced their seizure in another room.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had individualised personal plans in place which are intended to highlight residents' needs and provide guidance for staff in meeting these needs. The inspector reviewed the personal plans of two residents and noted that they were subject to multidisciplinary input in keeping with the requirements of the regulations. Processes were also in place for residents to be involved in the reviews of their personal plans and the development of goals through person-centred planning. In one of the personal plans reviewed it was seen, it was seen that that the resident's family had been involved in this process which included an information gathering process. Once this was completed a meeting was held in April 2024 to identify the goals for the resident to achieve. These included goals such as visiting the library and it was seen that time frames and responsibilities had been assigned for supporting the resident with these goals.

In the other personal plan reviewed during the day of inspection the only documentation present relating to the resident's person-centred planning was from early 2023. This was queried with a staff member present at the time and no further documentation in his regard was provided on the day of inspection. Following this inspection it was indicated that additional documentation had become dislodged from the resident's personal plan and that the resident had goals identified in March 2023 which were reviewed in June 2023, December 2023 and April 2024. Such goals included community integration, maintaining contact with family and attending a concert. It was also indicated post the inspection that the resident had been supported to achieve some goals while others were ongoing.

Both of the personal plans reviewed contained guidance on supporting residents'

needs. For example, one resident had detailed dementia support plan and intimate care plans given their particular needs. It was highlighted though that the other resident was experiencing cognitive decline at the time of inspection but no support plan was seen in the resident's personal plan about this. Variance was also noted between both personal plans reviewed regarding the format of support plans for health needs. In the report of provider unannounced visit to the centre from June 2024, which was provided in the days following this inspection, it was seen that the auditor had reviewed the personal plan of a third different resident. Subsequently the auditor made a number of recommendations related to the contents of that resident's personal plan in terms of the guidance in supporting the resident's health needs.

Such findings coupled with the findings of this inspection indicated that aspects of residents' personal plans needed improvement. However, when reviewing incidents records relating to a different resident during this inspection, the inspector queried if the resident had a support plan around supporting the resident with health appointments given their needs in this area. The inspector was informed during the inspection that there was not but following the inspection a relevant support plan in this area from April 2024 was provided to the inspector.

Judgment: Substantially compliant

Regulation 6: Health care

During this inspection, records reviewed indicated that residents were supported to attend or avail of appointments or reviews with various health and social care professionals such as general practitioners, dentists, neurologists and psychiatrists. The inspector read records of residents being supported to avail of vaccines while a resident who was eligible to avail of a national screening service had recently accessed this. Issues related to guidance on residents' health needs is addressed under Regulation 5: Individualised assessment and personal plan while concerns around the use of a rescue PRN medicine for one resident are highlighted under Regulation 29: Medicines and pharmaceutical services.

Judgment: Compliant

Regulation 8: Protection

Incidents occurring in the designated centre which had been deemed to be of a safeguarding nature had been screened with safeguarding plans put in place where necessary. Staff members spoken with during this demonstrated an awareness of active safeguarding plans in place. Records provided indicated that all staff had

completed relevant safeguarding training.

Judgment: Compliant

Regulation 9: Residents' rights

Positive examples of residents being treated in a respectful manner were noted during this inspection. These included;

- Staff interacting with resident in a pleasant manner
- Staff knocking on residents' bedroom doors before entering
- Staff holding regular residents' meetings with residents to give them information.

However, when reviewing the notes of such meetings, which were communal meetings, it was noted that some made reference to medical appointments of individual residents. For example, at one meeting the notes indicated that residents present were informed about the medical appointment of a resident who was not attending the meeting. This did not promote resident's privacy.

In addition, when reviewing incident records in the centre, the inspector read a report of an instance where a resident had locked their bedroom door. A staff member then proceeded to entered the resident's bedroom by first entering the bedroom of another resident and then using the bedrooms shared en suite bathroom. It was unclear why this was done from the incident report reviewed.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Lios Mor OSV-0004745

Inspection ID: MON-0042968

Date of inspection: 03/07/2024

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
• The staff compliment for Liosmor is 5 staff by day and 3 by night, with a 4th staff on duty until 22:00hrs.

• We are currently recruiting support workers for 2 x 25hr contracts to provide the twilight cover until 22:00hrs.

• In the event of staff shortages or increased staffing requirements e.g. to support a resident during a hospital admission, the contingency plan to maintain staffing levels in Liosmor is to use Liosmor's pool of relief staff, the Limerick relief roster and to liaise with Foynes/Bawnmore/Area Managers for additional support.

• The roster for Liosmor has been amended to include the actual hours of the night staff, instead of ND (night duty).

• The PIC hours are now included in the Liosmor roster, as well as the on call roster.</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• All staff who do not have up to date training in PPE and hand hygiene will complete these on HSEland by 3rd October 2024 and forward certs to PIC for inclusion on the training matrix. One staff, who is on long term sick leave, will complete her refresher training before returning to work.

• Of the 4 staff who did not have current food safety training at the time of the inspection, one staff no longer works in the designated centre, one staff completed the training on the 4th July 2024 and the other two staff have been booked to complete training by 3rd October 2024.</td></tr>
</table>

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Provider unannounced visit will be carried out prior to the 18th December 2024 to ensure completion within the 6 month timeframe.

• Tracking document to be completed by the PIC and PPIM (Area Manager), for this designated centre, in order to track progress on each action arising from this inspection.

• This will be monitored on a monthly basis between the PIC and PPIM (Area Manager) where evidence of actions achieved can be reviewed.

• A quarterly update of this monitoring will be submitted by the PIC and PPIM to the Head of Community Services (first monitoring to be completed end of Q3 2024) who will review same and provide assurance to the Director of Services that recommended actions are being progressed appropriately.

• Any issues/recommendations identified that cannot be addressed locally will be escalated within the management structure.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose for the designated centre has been updated to include the addition of the twilight hours.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• PIC discussed complaints at staff meeting on 24th July 2024 and this will remain on the agenda for staff meetings going forward.

• All staff have been requested to read the Complaints policy and familiarize themselves with their responsibilities.

• Easy Read Complaints procedure will be discussed with residents at residents’ meeting on 10th August 2024.

• Any complaints raised at residents’ meetings or any other forum, will be logged in complaints log and complaints procedure followed.

• PIC will attend residents’ meeting once a fortnight and will review the minutes of all other residents’ meetings to ensure that any issues raised are identified as complaints, logged appropriately and escalated where required.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• A weekly activity planner is in place to ensure that all residents are afforded equal opportunity to go on social outings.

• In the event that there isn't adequate staff in place to facilitate social outings, due to unforeseen leave or emergency cover in hospital, additional staff will be sought as per the contingency plan where possible.

• If it is not possible to roster additional staff to facilitate this, the activity planner will be reviewed to ensure residents can be accommodated to go on social outing on an alternative day.

• Staffing in relation to day service has been escalated through advocacy and business cases have been submitted by the day service management team for increased staffing.

• A formal complaint for one resident was escalated to the complaints officer in the day service in relation to the reduction in her day service hours.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• Residents' breakfasts will be prepared by staff when they come to the dining room and they will be offered their choice of breakfast as well as how they would like it prepared i.e. hot/cold

• Where a resident is unable to indicate a preference, staff will offer different options and monitor reaction to determine likes and dislikes. If a food is offered that resident clearly does not want or like, an alternative will be offered.

• Where a resident has expressed a preference that his breakfast be ready and on the table when he gets to the dining room, this will be reflected in his Personal Information Guide. Staff will prepare his breakfast and keep it in the fridge until he is ready to come to the dining room.

• All meals will be prepared in line with any relevant plans, such as EDS plan, Dietetics plan to ensure that it is consistent with the specific dietary requirements of each resident.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

• PIC discussed the importance of completing cleaning checklists at staff meeting on 24th July 2024 and this will remain on the agenda for staff meetings going forward.

• CNM1 will check the cleaning checklist each week to ensure that all required cleaning is completed and report any non-compliance to PIC.

• Bottle of hand sanitizer was disposed of. Only wall mounted hand sanitizer is to be used going forward. This is available in all toilet areas, on each corridor and at Liosmor entrance. Expiry date will be monitored to ensure that it is replaced before expired.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Resident's epilepsy care plan has been reviewed and clear protocol is in place, which is consistent with the prescription of PRN medicine.

• A medication storage unit has been sourced which will be placed on the wall in a central location in Liosmor. Buccolam will be stored in this unit for prompt administration. The storage unit will be locked using a combination code which will be known to all staff therefore the drug keys will not be required to access the medication.

• All staff who are trained in the administration of Buccolam are responsible to ensure prompt administration of rescue medication in the event of a resident sustaining a seizure, as per their individual protocol.

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 changeover to a new format of the My Profile My Plan for each resident is currently underway and will be completed by 30th October 2024.

• All new MPMPs will be reviewed by CNM1/PIC/PPIM on completion.

• The new MPMP will include more detailed personal plans for each resident in relation to existing needs and will be reviewed, at a minimum, every 6 months, or when there is a change in need or circumstances.

• Where a resident is under review by a healthcare professional i.e. GP, Consultant, MDT for a particular issue, a healthcare plan will be developed.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• PIC held staff meeting on 24/07/2024 and discussed the importance of personal information relating to residents not being shared at residents' meetings unless the

resident chooses to do so.

• Following discussion with Head of QET, it was agreed that a restrictive practice was required in relation to staff entering a resident's bedroom via ensuite, when she locks her bedroom door. This is done for safety reasons because the resident is at high risk of falls due to postural hypotension.

• Restrictive Practice decision making document has been completed and circulated to MDT to consider the proposed restriction. MDT will be held on 13/08/2024 to discuss this proposal.

• Protocol around checking on resident when she locks her bedroom door to be developed in conjunction with behavior support team in order to minimize intrusion into resident's privacy, while maintaining her safety.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	12/08/2024
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	30/09/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and	Substantially Compliant	Yellow	24/07/2024

	actual staff rota, showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	03/10/2024
Regulation 18(2)(a)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	31/07/2024
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Substantially Compliant	Yellow	31/07/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Substantially Compliant	Yellow	30/11/2024

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	18/12/2024
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	31/07/2024

	associated infections published by the Authority.			
Regulation 29(4)(b)	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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	30/09/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	29/07/2024
Regulation 34(1)(b)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall make each resident and their family aware of the complaints	Not Compliant	Orange	31/08/2024

	procedure as soon as is practicable after admission.			
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Not Compliant	Orange	10/08/2024
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	31/08/2024
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.	Substantially Compliant	Yellow	30/11/2024
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	Substantially Compliant	Yellow	30/11/2024

	frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
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	30/09/2024