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:	Lorrequer House
Name of provider:	St Michael's House
Address of centre:	Dublin 14
Type of inspection:	Unannounced
Date of inspection:	12 March 2025
Centre ID:	OSV-0003783
Fieldwork ID:	MON-0046660

About the designated centre

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

Lorrequer House provides 24 hour supports for up to six adults with intellectual disabilities. It is located in a cul-de-sac in a suburban area of south Dublin. The centre is a detached dormer bungalow with a driveway to the front and a patio, outdoor dining area, and garden space to the rear. On the ground floor of the building there is an entrance hallway, a large living room, a kitchen and dining space, a utility room, boiler room, three residents' bedrooms and three bathrooms. The first floor of the centre contains three residents' bedrooms, a staff sleepover room, a reading area, a toilet and a bathroom with shower facilities. The house is staffed by social care workers, nurses and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 12 March 2025	10:15hrs to 16:15hrs	Sarah Cronin	Lead
Wednesday 12 March 2025	10:15hrs to 16:15hrs	Kieran McCullagh	Support

What residents told us and what inspectors observed

From what residents told us, and what the inspectors observed, residents were receiving person-centred care in line with their assessed needs. The inspection had positive findings, with significant improvements made in a number of regulations since the last inspection. However, improvements continued to be required in staffing arrangements, and in training and staff development. These will be discussed further in the body of the report.

Lorrequer House provides a full-time residential service to six adults with intellectual disabilities. The house is a large dormer bungalow in a suburban area of south Dublin. Downstairs comprises a large sitting room, utility room, kitchen, bathroom, and three residents' bedrooms. Upstairs there are three more residents' bedrooms, an office area for a resident to use, a staff sleepover room and two bathrooms. The house was found to be clean and warm, and each of the residents' bedrooms were decorated to reflect their unique preferences and style. One resident spoke about some of the areas of the premises they would like to improve including making flooring level to avoid tripping on door saddles. The person in charge reported that the provider had plans to modernise parts of the centre in the months following the inspection, which included replacing flooring.

Residents living in the centre communicated largely through speech, body language, vocalisations, gestures, and at times, through behaviours. Inspectors had the opportunity to meet five of the residents on the day of the inspection and speak with them about their experiences living in the centre. On arrival to the centre, residents were going about their morning routines, with two residents chatting at the table, and another resting. One resident was on their way to their politics class in a local college, while two others were at their day service.

Residents reported that they were happy in their home, and that they felt safe. One resident described the staff were "good" to them. They were resting in bed and showed an inspector their call bell to alert staff if they needed support. They told the inspector that *"they always come very quick and they mind me"*. However, there were a number of staff vacancies in the centre, and residents told inspectors that they did not always know the staff supporting them, and how they did not like this. One inspector had the opportunity to sit with two residents in the morning as they finished their lunch, and spoke with another two residents later in the day as they enjoyed a cup of tea together. Residents spoke about some of the things they enjoyed doing such as going to day services, going out for a meal or shopping and one resident spoke about enjoying baking. Inspectors viewed photographs in residents' personal plans of them engaging in a range of activities in their home, and in their community. One resident had a job in a local clothing store, others were completing accredited courses, attending a literacy group and getting their nails done. All of the residents had personal goals in place, and a tracker was kept to ensure that they were supported to achieve these goals in a timely manner.

While staff members had not all completed training in human rights, it was evident that the provider was endeavouring to support residents to exercise their rights. For example, the majority of residents living in the centre had opened their own bank accounts since the last inspection. The person in charge spoke about supporting residents to develop skills to learn about their money and using their bank cards. Work was ongoing for another resident to gain full access to their finances. A vehicle had been purchased for the centre to support residents to attend appointments, and access community settings.

Residents in the centre presented with complex and changing care and support needs related to different healthcare diagnoses. This meant that a significant amount of time was used to support residents to attend medical appointments, and to liaise with local health and social care professionals. The needs of one resident had an impact on other residents due to being awake at night and vocalising. The person in charge and other members of the multidisciplinary team had given residents an opportunity to learn about their peer's diagnosis in order to understand some of the changes they were observing in their behaviour. There were plans in place to transition residents to more suitable accommodation to best support their health-care needs, and this was being done in liaison with the multidisciplinary team, and with input from family members.

Inspectors reviewed a sample of minutes from residents' meetings and found that they were now structured and well documented. The person in charge had oversight of the minutes to ensure that where any issues or concerns were raised, that they could follow up on with residents on an individual basis. The agenda included things such as choices for the week ahead, planning meals and speaking about complaints.

In summary, inspectors found that residents in the house continued to be supported to engage in meaningful activities in line with their interests. They appeared to be comfortable in the company of the staff on duty, and interactions were noted to be kind. The next two sections of the report present the findings of the inspection in relation to the governance and management arrangements in the centre, and how these arrangements affected the quality and safety of residents' care and support.

Capacity and capability

This was an unannounced inspection which took place to monitor levels of compliance after a new registered provider took over the designated centre. Poor levels of compliance were found in March 2024, which resulted in the Health Service Executive (HSE) taking over the running of the centre under Section 64 of the Health Act (2007), as amended in July 2024. St Michael's House was charged with running of the centre under a service-level agreement on behalf of the HSE as the registered provider in July 2024, and became the registered provider in February 2025. This inspection found that the new registered provider had effective systems in place to monitor and oversee residents' care and support in the centre.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge and they were supported in their role by a service manager. They had a comprehensive understanding of the service needs and had structures in place to support them in meeting their regulatory responsibilities.

Staffing arrangements required review. There were a number of vacancies in the centre on the day of the inspection, and inspectors found this was having a negative impact on the residents living in the centre. While regular staff had received training in mandatory areas, inspectors were not assured of the arrangements in place for agency staff working in the centre. The provider was found to have appropriate systems in place to manage complaints.

Regulation 14: Persons in charge

Inspectors reviewed Schedule 2 information submitted in relation to the person in charge prior to the inspection taking place and found that they were suitably qualified and experienced in their role. The person in charge had worked in the centre for a number of years in their role prior to the new provider taking over the running of the centre. They demonstrated an in depth knowledge of each of the residents and their assessed needs.

Judgment: Compliant

Regulation 15: Staffing

As outlined at the beginning of the report, residents living in this designated centre had changing and complex medical needs and required the support and care of a stable and core staff team. While it is acknowledged that the current provider had only been legally responsible for the centre since February 2025, it was found that provider was not ensuring the necessary continuity of staffing in order to effectively meet and support residents' assessed and changing needs.

On the day of the inspection there were nine whole time equivalent (WTE) staff vacancies. Inspectors reviewed planned and actual rosters for the months of January, February and March 2025 and found there was an over reliance on relief and agency staff to cover vacant shifts, which was having a negative impact on both residents and permanent staff members. For example, following review of rosters inspectors noted that a total of 90 shifts were covered by different agency staff across the months of January and February and a further 55 shifts were to be covered by a number of different agency staff during the month of March 2025.

Furthermore, concerns relating to staffing were identified during the provider's most

recent six-monthly unannounced visit. Staff spoken with during this visit raised concerns and advised there was a large staff turnover and prolonged periods of time were spent inducting new staff members. This required consideration and review by the provider.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors reviewed the most recent training matrix with the person in charge which was maintained by provider's training department. Inspectors observed that the training matrix only reflected two permanent staff members training records which evidenced that mandatory training had been completed. However, there was no documentary evidence to assure inspectors that relief and agency staff had completed mandatory training in areas like safeguarding, managing behaviour that is challenging or fire safety. Given the reliance on the use of relief and agency staff, a system for the provider to review the training completed by relief and agency staff was required.

Furthermore, staff working in the designated centre were not in receipt of additional training in line with residents' assessed needs. For example, staff were not in receipt of dementia-specific training in order to ensure that all staff have the required skills, competencies and confidence to meet the assessed needs of residents.

Supervision and performance management meetings, that support staff in their role when providing care and support to residents, was not being completed for all staff. For example, regular relief and agency staff were not in receipt of formal supervision meetings. This posed a risk in this centre due to complex medical and changing needs of residents and required consideration and review by the person in charge and provider.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that there were good management systems to ensure that the service provided in the centre was safe, consistent and effectively monitored. The provider and local management team carried out a suite of audits, including audits on medication, safeguarding, fire, infection prevention and control, risk management and the premises. Audits reviewed by inspectors were comprehensive, and where required identified actions to drive continuous service improvement.

Inspectors reviewed a recent six-monthly unannounced visit, which was carried by

the provider. The action plan documented a total of six actions. Following review of the action plan, inspectors observed that the majority of actions had been completed and that they were being used to drive continuous service improvement.

Following a review of the most recent staff team meeting minutes since January 2025, it was demonstrated that they were taking place on a monthly basis. Incidents were reviewed for shared learning with the staff team and other discussion topics included health and safety, residents' assessed and changing needs, safeguarding and restrictive practices.

In addition, regular individual case management (ICM) meetings were taking place and attended by the provider's multidisciplinary team, person in charge and service manager. Meetings focused on residents with complex medical and changing needs and a review of meeting minutes demonstrated that the provider was actively future planning for these residents. For example, additional nursing staff had been employed and assessments had been completed by the provider's occupational therapist and speech and language therapist.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had established and implemented effective complaint handling processes. For example, there was a complaints and compliments policy in place. Throughout the duration of the inspection inspectors observed that staff were provided with the appropriate skills and resources to deal with a complaint and demonstrated that they had a full understanding of the policy in place.

Residents spoken with felt comfortable with raising concerns and providing feedback and told inspectors what they would do in the event they were unhappy with something. For example, one resident advised they would speak to the person in charge.

Inspectors observed that the complaints procedure in place was accessible and in a format that all residents could understand. For example, there was an easy-to-read version of the provider's policy, easy-to-read information on how make a complaint and an easy-to-read complaints form was available ro residents. In addition, inspectors observed that accessible information regarding complaints was displayed throughout the designated centre.

Residents were supported through the complaints process, which included having access to an advocate and staff support when making a complaint or raising a concern. There were no open complaints on the day of inspection.

Judgment: Compliant

Quality and safety

Inspectors found that residents were being supported to enjoy activities in line with their interests, and that they were enjoying a good quality of life in the centre. Residents were supported to make choices in relation to their daily routines, and their care and support. The provider had implemented a proactive model of care that was centred on the needs of each person in the centre, particularly in relation to their health-care needs. The person in charge was in liaison with a number of agencies and multidisciplinary team members to ensure that residents' holistic health-care needs were met. The provider was found to have appropriate measures in place to safeguard residents from abuse.

Risks were identified and managed in the centre, and there was evidence that adverse events were reported, and actions were taken as required to mitigate against future recurrence and to share learning with the staff team. The provider had taken effective measures to come back into compliance with Regulation 28: Fire Precautions and Regulation 29: Medicines and Pharmaceutical services, and these are discussed under each of these regulations below.

Regulation 26: Risk management procedures

Inspectors found that the provider had systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies. Inspectors reviewed the risk register for the centre, in addition to records of incidents and accidents which had occurred. The risk register demonstrated that the provider had identified a number of risks related to the centre, and for individual residents. The risk register was reviewed on a quarterly basis.

Incidents and accidents were overseen at provider level through the quality and risk department. From a review of incidents and accidents, it was evident that the provider had swiftly responded to identified risks in the centre. For example, following errors in medication administration, they had ensured that there was a nursing staff on duty at all times in the centre. Areas for learning were shared with the staff team at handovers, and at staff meetings.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had mitigated against the risk of fire by implementing suitable fire prevention and oversight measures. For example, inspectors observed fire and smoke detection systems, emergency lighting and fire fighting equipment. Following a review of servicing records maintained in the centre, inspectors found that these were all subject to regular checks and servicing with a fire specialist company.

Inspectors observed that the fire panel was easily accessed in the entrance hallway of the designated centre and all fire doors, including bedroom doors closed properly when the fire alarm was activated. Emergency exits were thumb lock operated, which ensured prompt evacuation in the event of an emergency.

The provider had put in place appropriate arrangements to support each resident's awareness of the fire safety procedures. For example, inspectors reviewed six residents' personal evacuation plans. Each plan detailed the supports residents required when evacuating in the event of an emergency. Furthermore, all residents had easy-to-read escape plans on file to follow in the event of an emergency.

Staff spoken with were aware of the individual supports required by residents to assist with their timely evacuation. For example, inspectors spoke with an agency staff member on duty who was fully aware of all evacuation routes, what to do in the event of an emergency, residents' personal evacuation plans and where the fire assembly point was located.

Inspectors reviewed fire safety records, including fire drill details and found that regular fire drills were completed, and the provider had demonstrated that they could safely evacuate residents in the event of an emergency during both day and night-time circumstances.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found that the provider had appropriate systems in place in relation to medication management and pharmaceutical services. All residents had access to a pharmacist. On a walk around of the centre, inspectors noted that each resident now had a locked box in their bedroom. The person in charge showed the inspectors one of these lockers and this was found to have additional locked space for out-of-date medications for return. Where controlled drugs were used, there was an additional locked box which was only accessible by nursing staff, and a register of controlled drugs was in place.

Medication management was subject to ongoing audit and review to ensure that safe practices were followed. One inspector spoke with a nurse on duty who demonstrated their auditing system, and how they reported any inconsistencies to management. A review of a sample of these errors demonstrated that appropriate actions was taken by the provider, both at the time of the incident report, and following this with the staff member involved. A further action had been put in place

in relation to nursing staff being available in the centre 24 hours a day.

Judgment: Compliant

Regulation 6: Health care

Inspectors found that residents were well supported to access the health and social care professionals they required. A review of three residents' care plans demonstrated that residents had access to a general practitioner (GP), medical consultants, a dietitian, ophthalmologist speech and language therapists, occupational therapists and physiotherapy. Residents had access to community public health nurses, palliative care, and dementia specialists.

Clear records were kept of appointments, and the person in charge demonstrated good oversight of residents' annual medical checks. Inspectors found that there was evidence of regular meetings between health and social care professionals, with integrated supports in place to ensure that residents were kept comfortable in their home.

Judgment: Compliant

Regulation 8: Protection

Inspectors found that the provider had policies and procedures in place to ensure residents were safeguarded from abuse in the centre. All staff had completed safeguarding training, and from speaking with staff on duty, they were aware of who to report any safeguarding concerns to. Residents spoke about how they could make a complaint or how they could raise concerns.

There had been 33 notifications relating to safeguarding which had been submitted to the Chief Inspector of Social Services in the 12 months prior to this inspection taking place. It is acknowledged that these incidents occurred during the transitional period between registered providers. These were largely related to residents' changing needs and resulting compatibility issues. Inspectors viewed the safeguarding log, safeguarding plans and correspondence with the HSE Safeguarding and Protection team and found that the provider had put a number of measures in place to ensure that all residents were safeguarded in the centre. This included an increase in staffing numbers to provide one-to-one support.

Inspectors viewed a sample of three personal and intimate care plans and found that these were suitably detailed to guide staff practices which promoted and upheld residents' rights to independence, privacy and dignity during these care routines. A review of two residents' financial records demonstrated that the provider had good

systems in place to monitor and oversee residents' finances to ensure that they were safeguarded.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Lorrequer House OSV-0003783

Inspection ID: MON-0046660

Date of inspection: 12/03/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • PIC works Monday to Friday providing continuity and support for staff in the centre • Roster reviewed regularly to ensure assessed needs of residents are supported and staff skill mix is reviewed and monitored accordingly • PIC ensuring continuity of staff with regular agency staff employed • There are 3 regular agency staff who remain on the roster while recruitment is ongoing, they have been in post for over 2 years in Lorrequer house • Two DSW staff have been recruited and allocated to Lorrequer house one commencing on 4/03/25 and the second staff commenced on 2/04/25 this staff had been working as agency staff within the centre for some time prior. • Two experienced SMH SCW staff have been redeployed to Lorrequer house to fill vacancies one commencing on 3/04/25, the second commencing on 16/04/25 • A further two SMH SCW will be moving internally from other established centers one due to commence on 1/06/25 and the second due to commence on 1/07/25 • Recruitment within SMH is ongoing and interviews are held regularly, Lorrequer House is a priority centre for allocation of staffing	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training audits have been updated to include the new staff and internal transfer staff that have moved into Lorrequer house • SMH relief staff training records are available via Relief co-ordinator • Regular relief records will be held in centre • Regular consistent agency staff who have been in Lorrequer house a number of years, training records will be held in centre and log developed to allow better oversight of	

same.
• Training on new MAS sytems was provided to all staff including the regular agency staff on 2/04/25
• Resident with dementia support needs has moved out to specialist dementia care centre within SMH but training around dementia was provided on 18/06/24 & 19/06/24, all regular and consistent agency staff attended this training.
• Regular agency staff are rostered for staff meeting to ensure updates and compliance with centre operations
• Support meeting system in place for SMH contracted staff, system to support regular agency staff and regular relief to be discussed and implemented
• PEP and Fire walk through will be completed with all regular relief & agency staff.
• Fire safety training for Lorrequer house took place in on 5/03/25 and regular agency staff attended this
• Agency/Relief induction sheet to be reviewed

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(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.	Not Compliant	Orange	31/12/2025
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	31/07/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2025