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:	Liskennett Centre
Name of provider:	St Joseph's Foundation
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	13 February 2025
Centre ID:	OSV-0004263
Fieldwork ID:	MON-0046053

About the designated centre

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

The centre is a congregated setting and provides a home to 14 residents. It is based in a community setting in county Limerick. The campus is based around an equestrian centre. All of the residents have high support needs and are supported individually by a high staff complement, mostly on a one-to-one basis. The designated centre is purpose built and comprises of 14 individual apartments, divided into three sections. Each resident's apartment has its own front door and all the apartments have been finished to a very high standard, with a kitchen, living,dining area, bedroom and shower facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 13 February 2025	07:35hrs to 16:30hrs	Robert Hennessy	Lead
Thursday 13 February 2025	07:35hrs to 16:30hrs	Conor Dennehy	Support

What residents told us and what inspectors observed

This was an unannounced inspection by two inspectors which was part of an overall focused programme of inspections for the registered provider. From what the inspectors observed and from speaking with staff and residents in the main residents were receiving good care and support in this centre. The last inspection of the designated centre took place in April 2024, which had mixed findings for the provider with some regulations not compliant.

The designated centre was made up of a series of individual apartments which had capacity for 14 residents. Eight of the apartments were located in a courtyard setting and were part of the same building that included a reception, a visitors' room and a multipurpose room. Two other apartments were spread out over two floors of a detached two storey-building while the remaining four apartments located in a row as part of another building. The residential buildings were located next to day service buildings and next to an equine centre which were accessible to residents. The centre was in a rural setting, with large open areas and green spaces for the residents to use. Residents appeared to use these outdoor spaces regularly.

On the day of inspection 13 residents were present with inspectors meeting with eight of them. One resident was at their family home during the inspection. The "Nice to meet you" documentation was given to the staff to explain to the residents in an easy to read document why the inspectors were present in the centre. Residents and staff were later seen discussing this document. The inspectors arrived early in the morning in the centre. One inspector spoke with staff who were working through the night and the other inspector did an initial walk around of the centre. At this time most residents were still in their individual apartments and one resident was resting in a communal area of the centre. While the inspector was on the walk around they were requested by a member of the management team to remain in areas of the centre as their presence in some residents' areas may have an impact on them. While there, one of the inspector sought to view the ground where the apartments were based. A member of the centre's management requested to accompany the inspector during this which was accepted. While viewing the grounds, the inspector was then requested to direct his vision in a particular direction by the member of management this was to preserve the dignity of resident. The inspector complied with this request and the inspectors based themselves in the visitors room following this. While in the visitors room a resident came in to greet the inspectors and the resident appeared happy and content and left shortly afterward with their staff.

Later in the day both inspectors had a walk around of the premises. Some residents chose not to engage with the inspectors and one resident had gone back to bed for a rest. The residents apartments that were viewed by the inspectors were nicely presented and personalised with items such as family photographs. The staff interaction with the residents during this walk around showed that they knew the residents communication needs well. For example, one of the inspectors was

instructed by staff to write down questions for the resident that could be answered with yes or no answers. During this discussion the resident indicated that they were unhappy about something. The inspector asked a member of the staff team about this and the staff member expressed it was in relation to an activity they had recently tried and did not enjoy. Residents were observed undertaking daily tasks and going on activities with staff throughout. The centre had dedicated transport for residents in the centre.

Again, in the afternoon interaction with the residents was limited, one resident appeared to be anxious in the presence of the inspectors. One inspector, because of this, moved from the staff office to the visitors room and remained there for the rest of the inspection. The resident entered the visitors room while the inspectors were there and on the second entry the resident removed an item of food from one of inspectors bag and left the room. Near the end of the inspection the resident again appeared anxious, the inspectors stayed inside the visitors room until the resident was not in the area before they left the centre.

Staff members were seen to work well with residents throughout the inspection. Most of the staff team in the centre on the day spent time speaking with inspectors. The staff spoken with knew the residents they were working well and knew their day to day needs. Staff were seen to supporting residents through their activities, during household chores and meal preparation. Some staff had limited knowledge of support documentation for other residents to provide guidance when working with them this is further discussed later in the report.

The parts of the centre that were seen, were clean, homely and well decorated. A replacement heating system had recently been installed in the centre and the temperature in the centre appeared to be at a suitable level.

The inspectors also spent time reviewing documentation as part of the inspection process.

The next two sections of this report will 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 provided.

Capacity and capability

This centre is run by St Joseph's Foundation. Due to concerns in relation to overall compliance levels from inspections of St Joseph's Foundation’s designated centres and other regulatory engagement throughout 2024, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's designated centres. All inspections conducted for the duration of this programme will be unannounced and will have a focus on specific regulations. These regulations are Regulation 5 Individualised assessment and personal plan, Regulation 7 Positive

behavioural support, Regulation 8 Protection, Regulation 9 Residents' rights, Regulation 10 Communication, Regulation 16 Training and staff development, Regulation 23 Governance and management, Regulation 31 Notification of incidents, and Regulation 34 Complaints procedure. These regulations were reviewed on this inspection and this inspection report will outline the findings under each regulation. Due to concerns raised by information of concern received Regulation 26 Risk management procedures was also reviewed.

There was a clear management structure in the centre. There were arrangements put in place by the provider to maintain oversight in this centre. This provider oversight was maintained through reporting and auditing structures and there was evidence that ongoing efforts were being made to ensure the centre was in compliance with the regulations. The person in charge had oversight of the centre and also oversaw another designated centre in the overall organisation of the registered provider. They were supported by an area manager. The person in charge was also supported by two clinical nurse managers and a team of nurses and healthcare assistants.

The staff and management team were were familiar with the residents living there and were committed to providing quality service for the residents. There was a clear management structure present and overall there was evidence that the management of this centre were maintaining good oversight and maintained a strong presence in the centre. The person in charge was present on the day of this inspection along with a person participating in management. The person in charge provided good day-to-day support to staff and residents.

Staff spoken with on the day of inspection were aware of the needs of the specific residents that they supported. The knowledge of staff in relation to other residents in the centre that they might not directly work with is discussed further in the report.

Regulation 15: Staffing

The number and skill mix of staff was suitable for the number and assessed needs of the residents. There was adequate staffing in relation to the size and layout of the building. The staffing levels were in line with the centre's statement of purpose. One to one staffing levels were maintained for the residents that required it.

Planned and actual staff rosters were viewed over a four week period. It was evident that suitable staffing levels were maintained in the centre over this time.

Inspectors met with ten staff members on the day of the inspection. The staff working in the centre on the day of the inspection were knowledgeable of the residents they were specifically working with on the day.

A sample of four staff files working in the centre were provided in an electronic format and were reviewed by the inspector. The provider was seen to have

oversight of all of the appropriate information and documents as set out in Schedule 2 of the regulations. This included evidence of Garda vetting and written references.

Judgment: Compliant

Regulation 16: Training and staff development

The inspectors reviewed the training matrix of the centre. This record of training was kept under regular review. Training of staff had been kept up to date with all mandatory training undertaken in line with the providers training policy. Dates for further updates in training were provided. Some staff in the centre had completed fire safety training on the day before the inspection. The training needs of staff were being appropriately considered and this meant that residents could be provided with safe and good quality care and support appropriate to their needs.

Staff supervision was being completed on a quarterly basis in the centre in a structured manner. Evidence of this was provided to the inspectors on the day of inspection.

Within the centre, copies of the provider's safeguarding policy, relevant national safeguarding policy and standards on adult safeguarding were present for staff to reference when they required.

Judgment: Compliant

Regulation 23: Governance and management

This inspection found that the provider was ensuring that this designated centre was adequately resourced to provide for the effective delivery of care and support in accordance with the statement of purpose. Management systems in place were ensuring that the service provided was appropriate to residents' needs. Evidence of staff meetings and residents meetings taking place regularly were provided to the inspectors.

An annual review had been completed in respect of the centre and the inspector reviewed this document. This included evidence of consultation with residents and their family members. Unannounced six-monthly visits were being conducted by a representative of the provider and records related to these were reviewed. These unannounced visits are specifically required by the regulations and are intended to review the quality and safety of care and support provided to residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had notified the Chief Inspector of Social Services in writing, as appropriate, of any incidents that had occurred in the designated centre. For example, the Chief Inspector had been notified of losses of heating in the centre. Safeguarding issues had been identified in the centre and notifications were submitted for these incidents.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints policy in place. There was evidence that residents and their representatives would be supported to raise issues or concerns and that these concerns would be taken seriously and used to inform ongoing practice in the centre. The complaints log was reviewed and complaints logged there had been closed out and the satisfaction levels of complainant was recorded. It was seen that complaints were recorded as appropriate in this log, including any actions taken on foot of the complaint, the outcome of the complaint, and the satisfaction of the complainant. The person in charge spoke about the complaints that had been received in the designated centre and how these were responded to.

Other complaints were received by the registered provider regarding the centre. It was not evident that all management involved in the centre were aware of these complaints. Assurances were provider to the inspector later in the inspection regarding this.

Judgment: Substantially compliant

Quality and safety

There was clear governance structure in place and the centre was adequately resourced to provide a suitable service for residents in this centre. The well being and welfare of residents in this centre was being maintained by a good standard of evidence-based care and support. The residents in the centre appeared to be content with the staff working with them striving to uphold their rights.

Residents documentation and personal plans contained suitable information on the communication methods used by the residents and how staff may support them in

these methods. Risk management processes in the centre were appropriate and well managed.

Residents personal plans contained assessments and meaningful goals for the resident. Some guidance in the personal plans were unclear for staff work with, this is discussed under Regulation 5.

Staff directly working with the residents on the day of inspection knew the specific residents' needs well. Staff knowledge on how to support some of the residents and their safeguarding needs was not evident during the inspection. Safeguarding was a topic discussed at team meetings but staff knowledge was lacking when speaking with the inspectors. In the area of positive behaviour support for residents, one staff member was unaware of the positive behaviour support plan for the resident. Two residents were awaiting updated guidance in relation to positive behaviour support, this guidance was under review from the multidisciplinary team. This was acknowledge as an issue as the service was awaiting the appointment of specialists in the area.

Regulation 10: Communication

From a review of residents' personal plans it was evident that staff working with the residents had access to guidance in the area of methods of communication used by residents. This information was outlined in specific resident communication profiles. These profiles were seen to be comprehensive with information on how residents indicated yes or no, how the person requested items and how they would ask for help. From observations of the staff interacting with residents on the day it was evident that the staff were employing these communication when supporting residents. An example of this would be staff communicating using hand gestures for the resident to reassure them and it was evident the staff member was communicating in the residents preferred communication method. Information throughout the centre was made available to residents in an accessible format.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a system in place to record and review incidents in the centre. The provider had a risk management policy in place for identification, assessment and review of risks in the centre. This policy also addressed specific risks as outlined under this regulation. A risk registered was maintained in the centre for overall and individual risks for residents. Risk assessments for the risks identified outlined control measures involved in mitigating the risk. The risk assessments had been reviewed in the previous 12 months.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed five individualised personal plans during the inspection. The personal plans and assessments had be subject to review in the previous 12 months. Assessments in these plans included areas relating to residents' needs such as their health and the support they required in their activities of daily living. A support plan was put in place to respond to the need of the resident which provided guidance to staff on how to support this need.

It was evident that the residents' personal plan and their needs were reviewed by the multidisciplinary team annually. The personal contained a person centred plan that identified goals for the resident. It was evident and their families were involved in the setting of these goals. These goals were monitored and progress noted. For one resident it was not clear if a goal was being progressed but the person in charge was able to give an update on this. It was documented for one resident that the progression of their goals had been impacted due to their presentation at the time.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required residents had information contained within their personal plans which contained guidance for staff on how to support the residents to engage in positive behaviour. Such information included strategies to adopt with residents depending on their presentation. However, not all staff spoken with on the day of inspection had awareness of positive behaviour support plans of the residents. This did not provide assurance that they had been fully informed of how to support the residents to engage in positive behaviour.

The guidance that was present in residents' personal plans had been written up by either a behavioural specialist or a psychologist. It was highlighted though that the provider's behavioural specialist post had not been filled in recent times. Records reviewed related to one resident indicated that because of this their positive behaviour support had not been reviewed since January 2024 and that a six monthly review related to this had been missed. It was acknowledged though that during this time frame the resident was subject to multidisciplinary review. Inspectors were informed that the registered provider was in the process of recruiting two behavioural specialists, that the relevant resident had been reviewed by the provider's psychologist and that the centre was awaiting updated guidance for this resident to be provided. Updated guidance for another resident was also awaited at

the time of this inspection. The lack of availability of specialist positive behaviour support wasidentified by the person in charge as a concern.

When reviewing one resident's documentation, an inspector noted that the resident had a protocol written up on when the residents was to receive a particular PRN medicine (medicines only taken as the need arises). However, when reviewing this protocol the inspector observed that there was inconsistent information in the document regarding the maximum dose of the PRN medicine that the resident was to receive in a 24 hour period.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had in place a designated officer (person that reviews safeguarding concerns) for this centre and information on this person was available in the communal areas of the centre. Most staff were aware of who the designated officer was and how to report a safeguarding concern.

- One staff member, however, was not knowledgeable of the designated officer and could not identify who a staff member might raise a concern to outside of the management of the centre.
- Additionally, not all staff demonstrated an awareness of all safeguarding plans in the centre. For example, one staff member informed an inspector that there was one active safeguarding plan in the centre but documentation reviewed indicated that there was 22 active safeguarding plans. The safeguarding plans in the centre highlighted that the staff working in the centre needed to be aware of same. It was acknowledged that some of these safeguarding plans were similar in nature and involved the same residents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were seen to be well supported by staff on the day of the inspection. Staff and management interacted with residents in a kind and respectful manner from what the inspectors observed. Examples of this, staff were seen knocking on apartment doors when coming on duty in the morning to request access and were then heard asking the resident how they were, when they entered the apartment.

Documentation also provided indicated that one-to-one meetings between residents and staff were taking place. An inspector reviewed a sample of such meeting notes for three residents and noted that these meetings were used to give residents

information in areas such as safeguarding, complaints, activities and meals. While inspectors were informed that these meetings were to take place on a weekly basis as outlined in the centre's statement of purpose, the notes reviewed indicated that this was always the case. For example, one resident had no such meeting between 15 December 2024 and 26 January 2025. The person in charge informed inspectors that they had previously raised such meetings with staff in November 2024 with a view to improving their content and frequency.

Residents had access to adequate communal and also space to under activities in private. Residents were seen to undertake various activities during the day of inspection. The inspectors were informed that Wi-Fi was available to all residents in the centre and residents had televisions in each of their apartments.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Liskennett Centre OSV-0004263

Inspection ID: MON-0046053

Date of inspection: 13/02/2025

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 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: As highlighted in response to regulation 23, on the day of inspection there was some confusion when inspectors questioned staff regarding a complaint received by the centre. As the complaint in question was submitted to the Office of the CEO from the Office of the Confidential Recipient, the complaint was dealt with directly by the CEO. The PIC, Area Manager and Complaints officer did not realise that HIQA were querying this particular complaint; Once clarity was obtained this complaint was then discussed with the inspector. The Person In Charge wishes to confirm to the Chief Inspector that all members of senior management in the centre were aware of this complaint.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The Person In Charge wishes to assure the Chief Inspector that all staff will be made aware and brought up to date on all residents positive behaviour support plans. This was completed at staff team meeting held on the 4th April 2025 and will be discussed in detail with individual staff through supervisions. In addition the Provider can confirm that it has successfully recruited two behavioural therapists, one of which will be based in the Liskennett centre to support both its residents and its staff. The behaviour therapist will take up their post on 9th April 2025. Regarding the awaited updated guidance on a particular resident, the Peron In Charge can confirm that a full functional behavioural assessment will need to be undertaken prior to any guidance being issued. This task will be completed by the incoming behavioral therapist; interim guidance may be provided by the behavioural therapist	

while the functional assessment is ongoing.

Regarding a residents protocol and when to receive a PRN, the Person In Charge wishes to assure the Chief Inspector that all documentation will be updated to reflect the correct maximum dose of PRN.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The Person In Charge wishes to assure the Chief Inspector that the staff member in question has been made aware of who the designated officer is and their contact details. In addition The Person In Charge wishes to assure the Chief Inspector that this was addressed with all staff at the centre's team meeting which took place on 4th April 2025.

Furthermore a discussion regarding open safeguarding plans for the centre was also discussed at the same staff meeting on 4th April 2025. Prior to this meeting staff have been tasked with familiarizing themselves with all open safeguarding plans within the centre. The oversight of same is held by the Person In Charge.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The Person In Charge wishes to assure the Chief Inspector that going forward residents meetings will be held weekly; the oversight of same will be held by the Person In Charge

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 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.	Substantially Compliant	Yellow	04/04/2025
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: the person nominated under paragraph (2)(a) maintains the records specified under paragraph (2)(f).	Substantially Compliant	Yellow	04/04/2025

Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	31/07/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	31/07/2025
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	19/05/2025
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and	Substantially Compliant	Yellow	04/04/2025

	participates in the organisation of the designated centre.			