



# 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:	21 October 2025
Centre ID:	OSV-0004263
Fieldwork ID:	MON-0048643

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

As part of our inspection, where possible, we:

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

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

### **1. Capacity and capability of the service:**

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

### **2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
Tuesday 21 October 2025	15:00hrs to 22:40hrs	Robert Hennessy	Lead
Tuesday 21 October 2025	15:00hrs to 22:40hrs	Deirdre Duggan	Support

## What residents told us and what inspectors observed

This was an unannounced inspection, by two inspectors, following information received by the office of the Chief Inspector of Social Services. There were 13 residents residing in the centre on the day of the inspection as one resident was at home with their family. 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 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 designated 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. The designated centre and the grounds surrounding it had been decorated very creatively for Halloween.

The inspectors met with the person in charge at the beginning of the inspection. One of the inspectors took a full walk around of the premises of the designated centre. The apartments were well maintained and personalised for residents. There were areas that required painting in the centre but there was a painter on site on the day of the inspection undertaking the work. There was one wardrobe door which came off the wardrobe. This was repaired by a maintenance person before the end of the inspection.

The inspector that completed the walk around met with 12 residents. One resident was attending an appointment and was not met by the inspectors. One resident gave one of the inspectors a tour of their apartment. Residents that required one to one supports from staff were receiving them. Staff were interacting with the residents in a kind and respectful manner. The management team in the centre also spoke knowledgeably of the residents and their needs. The residents were supported by staff to go through their daily routines and were assisting staff with household tasks. All residents had televisions in their individual apartments and had access to smart devices if suitable for them such as tablets.

There were three families visiting their loved ones during the inspection. Staff were seen to speak with the families in a kind manner. One family member spoke with one of the inspectors. They were mainly happy with the support the resident they were visiting was receiving in the designated centre. The family member of the resident did have concerns regarding inconsistent staffing used in the designated centre. The family member of the resident reported that this was a problem previously but no longer an issue. A compliment was viewed from another family member which thanked the staff for organising a milestone birthday for family member for a "wonderful day they organised".

Eleven of the staff members spoke with the inspectors with both day and night staff

being met. All staff were knowledgeable of the residents and were able to discuss the residents' particular needs. Some staff also identified inconsistent staff being used earlier in the year but the staff also reported that this was currently not an issue. Newer staff were met and spoke about receiving appropriate training and induction since they had started. The staff reported that they felt they were well supported by the management team in the centre.

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

Management systems in place in this centre were ensuring that overall the services being provided were safe and appropriate to residents' needs. This inspection found that the management and staff team in place in the centre were familiar with the residents living in the centre and were committed to providing an effective service that met their assessed needs. There was a clear management structure present and overall there was evidence that the management of this centre were maintaining oversight and that these individuals maintained a strong presence in the centre.

The person in charge had ensured that the staff team had received appropriate training to meet the needs of the residents. There was evidence of the training programme being monitored to ensure that the staff team remained up to date with training. There was a supervision schedule in place for staff.

Staffing levels were maintained in the centre to ensure the residents could be supported to undertake the activities they wanted. The staff team were knowledgeable of the residents' needs when they spoke with the inspector.

## Regulation 15: Staffing

Staffing levels were maintained at appropriate level to the number and the assessed needs of the residents and the layout of the centre. Staff rosters over a period of three months were reviewed. The staffing levels also corresponded to the staffing levels described in the statement of purpose. A planned and actual staffing rota was available on the day of the inspection. Two staff members spoke about previous concerns regarding inconsistent staff being used for residents but reported that this was not a concern at the time of the inspection. Staff spoken with on the day were very familiar with the residents' needs and spoke about them in a respectful

manner.

Judgment: Compliant

### Regulation 16: Training and staff development

The staff training matrix for the centre was reviewed. The training matrix showed that staff were provided with training appropriate to their roles and that the person in charge was maintaining good oversight of the training needs of staff. Dates for further updates in training were provided. 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. Training undertaken by staff included managing behaviour and safeguarding.

Judgment: Compliant

### Regulation 23: Governance and management

There was an appropriate management structure in the designated centre. A person in charge was in place supported by an area manager and a clinical nurse manager. The latest annual review for the designated centre had been completed on 10 March 2025. This was a thorough review of the quality of service provided to the residents. Residents' families provided feedback through surveys on a six monthly basis with positive feedback being received. Highlights for the residents were captured in this review also. This report was made available to the inspectors.

The six monthly unannounced provider audits had been completed and actions had been identified and were being undertaken. The last six monthly unannounced provider audits had been completed in June 2025 and December 2024. Internal audits were being completed in a timely manner such as personal plan audit and medication management audit.

Staff meetings were taking place on a monthly basis which discussed such topics as safeguarding and advocacy. Staff spoken with reported that they felt comfortable, if they had concerns, speaking about them at these meetings.

Judgment: Compliant

### Quality and safety

The person in charge had ensured there were relevant assessments undertaken and personal plans in place for the residents. These were reviewed in a timely manner. These plans contained information on residents' needs in relation to health care and also on how they communicated and how they liked to be communicated with. Some of the personal plans viewed lacked details in relation to the personal development of residents and also one in relation to assisting one of the residents with personal care.

Residents' rights were respected in the centre and it was evident that the residents undertook a variety of activities. Some residents did not have control over their finances which goes against the registered provider's policy. The registered provider was aware of this and was working on a solution for this.

Risk was well managed in the centre and measures were in place for safeguarding of residents. Safeguarding concerns were managed in line with the registered provider's policy.

The premises was well maintained and issues regarding painting and a resident's wardrobe were being addressed during the inspection. The premises provided the residents with adequate private and communal space.

### Regulation 17: Premises

The inspectors had a full walk around the designated centre. The residents had access to sufficient communal and private space which was well maintained. The residents' apartments were equipped with comfortable furniture, well maintained bathrooms, cooking and laundry facilities. Residents' living areas and bedrooms were personalised and decorated in line with the residents' interests. Residents had mural artwork in their apartments which also reflected their interests such as sport and music.

A wardrobe door in one of the resident's apartment was seen to come away from its hinges. This was repaired during the inspection by the maintenance personnel that were on site.

Judgment: Compliant

### Regulation 26: Risk management procedures

There was a risk register in place for the designated centre. The risk register for the designated centre and individual residents' risks had been reviewed in the previous 12 months. The risk register of the designated centre contained suitable risk assessments this included what would occur if there was an emergency such as

adverse weather.

There was suitable risk management policy put in place which identified and contained the control measures for specified risks required under the regulation.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

Assessments and personal plans were viewed for three of the residents. Review of the personal plans had taken place in the last 12 months. There was evidence in the personal plans of multidisciplinary team involvement in supporting the residents throughout the year such as a psychologist and an occupational therapist.

Residents were undertaking various activities on the day of inspection. Some residents had appropriate goals for the year created. For two of the personal plans viewed it was unclear how the residents' personal development was being maximised in line with their wishes as it was not evident what goals the residents were trying to achieve or if these goals were being reviewed.

One resident had a personal health care device that required changing regularly. It was not clear from the personal documentation contained in their personal plan of the resident if this was occurring. Staff reported that this device was changed regularly as required but there was no documentation to support this.

Judgment: Substantially compliant

### Regulation 6: Health care

The health care needs of the residents were being well met with appropriate assessments completed in relation to these needs. There were clear plans in place for staff to follow in relation to the residents' health care needs. Residents had access to a medical practitioner and other health care specialists. One resident was being supported to attend a health care appointment in a medical facility on the day of the inspection.

Judgment: Compliant

### Regulation 8: Protection

All staff had received training in the area of safeguarding. The staff spoken with

during the inspection were aware of abuses that may occur and how these should be dealt with. Staff members were seen to speak with residents in a kind and respectful manner. The registered provider had an appropriate safeguarding policy in place.

The safeguarding incidents in the designated centre were managed in line with the registered provider's policy and the information was submitted to the relevant bodies. Safeguarding plans were in place and actions were being completed in relation to these for example body maps being completed. Staff spoken with were knowledgeable of the safeguarding plans in place.

Residents had intimate care plans to identify the supports the residents required in this area and what skills residents were able to undertake for their personal hygiene needs.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents had access to private space to engage in activities if they so wished. Residents appeared to be undertaking various activities throughout the week and residents were being supported to engage in new activities. Staff reported that residents were going on overnight trips, swimming and to the library. From documentation reviewed and from conversations with staff, residents that had previously undertaken little activities were now undertaking new activities such as going swimming as a new activity.

Staff were seen to be supporting residents well and were kind and respectful with the residents. One to one meetings were taking place between staff and residents to discuss areas such as safeguarding and complaints. Residents had access to Wi-Fi and had their own televisions in each of their apartments.

A rights restriction logged identified a restriction regarding residents finances. Residents did not have direct access to their finances. Such arrangements were not consistent with the registered provider's policy on residents' finances. This policy stated that the registered provider would "respect a resident's right to control their finances" and was "committed to supporting residents who use our services to use and manage their money". However, given that the restrictions in place relating to residents' finances, improvements were required by the provider to come into compliance in relation to residents being able to exercise their rights around their finances. The registered provider was fully aware of this issue and was working on a solution to give residents control over their finances. The registered provider had given a date of 31 December 2025 to resolve this issue.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
<b>Quality and safety</b>	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	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 Liskennett Centre OSV-0004263

Inspection ID: MON-0048643

Date of inspection: 21/10/2025

## 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 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>The Person in Charge wishes to assure the Chief Inspector that the two personal plans viewed on the day of the inspection are currently being reviewed. These residents goals will be fully updated in line with their will and preference by the 31/12/2025. The Person in Charge can confirm that these goals will be tracked and reviewed by the Named Nurse.</p> <p>The Person in Charge has oversight of these goals by auditing the “Life goals and support plan” section of each care plan monthly.</p> <p>The Person in Charge can confirm that a monitoring chart is now in place for the one resident that has a personal health care device to record and accurately document care being provided. This chart was put in place by the Person in Charge as of the 23rd October 2025 and is completed daily by staff in the centre. The Person in Charge will have oversight of this monitoring chart going forward.</p>	
Regulation 9: Residents' rights	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <p>The Provider wishes to confirm St. Joseph’s Foundation is actively reviewing its practices in terms of supporting residents to manage and access their finances. This involves reviewing and updating the policies impacting our residents, particularly our Finance and Restrictive Practice Policies, mindful of our responsibilities of implementing the Assisted Decision-Making Act 2015 and the Health Act 2007. As previously indicated, the Provider</p>	

has been liaising with its bank in regard to access to finances for its' service users. Following the most recent discussion with the bank the original implementation date of the 31st December 2025 unfortunately can no longer be met. The Provider wishes to assure the Chief Inspector that it is fully committed to resolving this and thus coming into compliance with Regulation 9. To that end, it is now envisaged that a solution will be implemented by 31st May 2026.

The banks compliance unit and its local compliance manager are involved at both local and national level in determining a solution.

The Provider wishes to assure the Chief Inspector that until this issue is resolved that monies are available to all residents at all times through the Finance department and in line with the Provider's Policy; To Support People who use our services to manage their money.

**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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/12/2025
Regulation 05(6)(b)	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 be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her	Substantially Compliant	Yellow	31/12/2025

	representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	31/05/2026