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:	Leamlara Residential Service
Name of provider:	Barróg Healthcare Limited
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	16 April 2025
Centre ID:	OSV-0008052
Fieldwork ID:	MON-0046844

About the designated centre

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

Leamlara Residential services provides full time residential care for up to two adults with an intellectual disability and autism. The centre is a large detached property located in a rural village in Co.Cork. Each resident is supported to have a private room, with ample communal space within the centre. A large fully equipped kitchen dining room and utility room is present. Full time staff support is provided to residents 24/7 throughout the year. Oversight of the centre is maintained by members of the governance team including the appointed person in charge and team leader. The mission statement of the centre is "to foster ongoing learning in each person the ability to value themselves"

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 16 April 2025	09:20hrs to 16:30hrs	Elaine McKeown	Lead
Wednesday 16 April 2025	09:20hrs to 16:30hrs	Robert Hennessy	Support

What residents told us and what inspectors observed

Following the receipt of unsolicited information to the office of the Chief Inspector, this unannounced risk inspection was completed to meet with the two residents who were in receipt of residential services in the designated centre on the day of the inspection and to review the systems in place to ensure a consistently safe service was being provided with effective governance and oversight in the designated centre.

On arrival both inspectors introduced themselves to the team leader who was on duty. One resident had already left the designated centre and the inspectors were introduced to the other resident before they also left to attend their day service. The resident greeted both inspectors and spoke about their plans for the day. The resident was observed to check they had all the equipment they needed to bring with them to their day service which included their tool box.

One inspector met with both residents again in the afternoon as they returned from their day service. One resident was observed to make themselves a hot drink and spoke with the inspector indicating they were happy living in the centre. They had moved into this designated centre in October 2024 and were able to visit family members more frequently as a result of the relocation from another designated centre operated by the same provider in another county. The second resident did not appear to want to engage in conversation with the inspector but indicated they were happy living in the designated centre. Both inspectors briefly interacted with this resident at the end of the inspection. The resident acknowledged the inspectors, understood they were leaving the house and appeared content with this.

The inspectors completed a walk around of the designated centre where issues relating to fire safety were immediately identified. These included two doors being prevented from closing, damage evident to door frames and evidence of excessive gaps under and over doors which impacted the effectiveness of fire containment measures. The provider was informed of the issues identified and an urgent action under Regulation 28: Fire precautions was issued to the provider during the inspection. This will be further discussed in the quality and safety section of the report.

Each resident had their own sitting room which was reported by staff to be working well for them. There was a multi-purpose room where residents' schedules and personal plans were available to them. One resident chose to lock their sitting room when out of the centre. This was observed to be in place during the inspection. The other resident allowed the inspector to see their bedroom and this was found to be well decorated with personal items and plenty of storage space. The residents each had their own individual bathrooms.

There was an outdoor area available to the residents. This was a large garden and it was an identified goal that one of the residents would create a vegetable patch. This

had yet to begin. In addition, staff had identified a number of suitable locations for the resident to engage in social farming. While the reasons the programme had not yet been confirmed for the resident were provided to the inspectors, staff outlined the possible benefits for the resident if it could be commenced. This will be further discussed in the quality and safety section of this report.

The inspectors were informed how the staff team were ensuring residents were supported to engage in other activities both within the designated centre and in the community. However, staff were constrained at times in being able to support one resident to purchase items such as treats if the resident didn't have sufficient funds in their bank account. Staff outlined the current arrangements regarding this resident's personal finances in place and how staff had to previously support the resident to count down to the number of days before they would have money in their bank account again. This was described as causing anxiety at times for the resident. While some improvements had been made in recent weeks, this will be further discussed in the quality and safety section of this report.

Staff also spoke of supporting residents to attend recent community events such as part taking in a recent St Patrick's Day parade. Additional staff were available to support both residents to attend the event and walk in the parade. While staff identified issues regarding the compatibility of both residents living together, adaptations to the house, which included a bedroom being re-purposed into a sitting room for one resident were currently working well. One resident was described as enjoying conversations, music and social activities while the other resident preferred a quieter environment and being on their own away from peers in the house. Staff outlined how both residents had successfully completed the cookery course together in the community but sharing communal spaces in the house was monitored by staff on an ongoing basis.

Staff had developed systems within the designated centre to ensure adequate nutritious food supplies were available to the residents while working within the allocated weekly budget set by the provider. This included a detailed shopping list of items and the quantity to be purchased as well as a review of what was already available in the house. There had been no increase in the weekly budget in recent months despite the rising costs for such items. Inspectors acknowledge as a result of these systems the staff team had ensured that the food available on the day of the inspection matched the menu planned for the residents for the week. Staff also encouraged the residents to adapt to the plastic bottle return scheme, with a dedicated storage box for the purpose in the designated centre. The money returned from these items was being added to the house budget and recorded in the finances records.

Staff also informed the inspectors that residents had not been supported to go on a planned short break in October 2024. Another short break was planned for December 2024. Both residents had been aware of the planned break and preparations had begun, which included social stories and easy -to-read information. However, the provider did not allow the planned break to go ahead citing the lack of funding available for the staff resources. One resident had a personal goal to go away on holiday in 2024, this was not attained. A resident had a day trip to another

county but this was not their original planned trip. The inspectors were advised the provider had indicated that the location of any planned holiday in 2025 for the residents would be decided by the provider. This was not reflective of the residents being involved in such decision making.

Inspectors reviewed a range of documents including audits, staff meeting notes, maintenance logs during the inspection. There was evidence that the staff team were consistently documenting issues relating to maintenance in the designated centre. These included a damaged table in the multi-purpose room, damage to the kitchen units and seating furniture that was not suitable for the assessed needs of one resident. Inspectors were only able to review documents from 1st January 2025 as archiving of 2024 documents had been completed and sent to the provider's offices in Dublin. However, issues were still evident to have not been resolved on the day of the inspection, this included the impeded opening of the dishwasher door due to an ill fitting kitchen unit underneath the appliance. Damage was also evident on other surfaces of kitchen units. The inspectors observed a washing machine in the utility room which was placed in front of an oil burner for heating. The location of both appliances together was observed to prevent access to the oil burner if it required servicing.

To support effective communication with the residents and meeting their assessed needs there were a large number of visual aids, such as picture boards used throughout the designated centre. These were being used to assist the residents to plan/explain regular activities, food and meal planning, staff working in the centre and signs to show which areas of the centre were communal/shared spaces and where spaces were private. There were certificates on display to show how the two residents had recently completed a cookery course and pictures of one of the residents who had cooked for their family following this.

The team leader ensured all requests made for documents during the inspection by the inspectors were responded to in a timely manner. The team leader was aware of their role and responsibilities to ensure the safety and well-being of the residents. Due to other duties, the person in charge arrived in the designated centre in the afternoon and also provided the inspectors with up-to -date information regarding this designated centre. This included that the planned admission of a third resident was not progressing and at the time of this inspection no other resident had been identified to move into the designated centre. Subsequent information from the provider during the inspection outlined an organisational decision had been made on 15 April 2025 that there would be no new residential referrals at this time.

Inspectors met with four support staff who were on duty during the inspection. Each staff was aware of the assessed needs of the resident they were supporting. One resident was supported by one staff during the day time and the other had two staff supporting them until 20:00hrs each day. The team leader outlined when activities were being planned in advance the daytime support hours could be adjusted to suit the resident to attend evening activities if they wished.

In summary, the provider had not ensured effective fire safety measures were in place in the designated centre. The provider had not demonstrated an adequate

response to issues raised regarding fire safety by the staff team. Residents had not been supported by the provider to attain personal goals. One resident did not have access to information such as bank statements regarding their finances and was unable at times to purchase items as per their expressed wishes due to the current constraints placed on them accessing their finances. The provider had not demonstrated adequate actions had been taken following concerns raised by staff members regarding issues such as residents finances and maintenance issues on the premises. The inspectors acknowledge the ongoing support provided and evidenced by the staff team to ensure the ongoing safety and well being of both residents. This included efforts to ensure each was supported to meet with family representatives regularly, to enjoy activities such as going to the cinema regularly and include each resident in decision making within their home.

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

Following the receipt of unsolicited information to the office of the Chief Inspector, this unannounced risk inspection was completed to ensure effective governance and oversight by the provider in the designated centre. This centre was registered as a designated centre in November 2021. The most recent renewal of the registration of this designated centre had occurred on November 2024. This designated centre was last inspected in September 2024 by an inspector of social services on behalf of the Chief Inspector. Not all actions identified by the provider in the compliance plan returned to the Chief Inspector following that inspection had been adequately addressed at the time of this inspection. This included not ensuring positive risk taking training had been provided to the staff team by 15 February 2025. The provider had also submitted an application to vary the standard conditions of the registration in December 2024 to increase the maximum capacity of residents from two to three residents. While the application had been granted by the Chief Inspector the decision had not become active at the time of this inspection.

During the inspection, the team leader outlined systems in place to ensure residents were being supported by staff resources in-line with their current assessed needs. This included ensuring at least one staff member on duty was trained in the safe administration of medications. All but two of the current staff team were eligible to drive the two transport vehicles available to the designated centre. While there was a limited number of social care staff available on the staff team at the time of this inspection, at least one was on duty at all times. Staff were aware if any changes were to be made to the planned roster, the skill mix of those on duty must be reflective of the residents availing of services on that day.

The flexibility demonstrated by the staff team was evident in a number of records reviewed and from speaking with staff on the day of the inspection. Staff facilitated both residents to spend time with family members. Changes to these visits in recent months had been facilitated, these included one resident not staying over night in their family home for a period of time. The overnight visits had re-commenced and were ongoing at the time of the inspection. Staff also supported the residents to attend community events such as the St Patrick's day parade. However, staff outlined how they had to make repeated requests to the provider before additional money was provided for the event. Ongoing daily review of the available money to purchase items for the designated centre was also required to be undertaken by the senior staff in the designated centre. Detailed records of the petty cash transactions since 1st January 2025 documented how the weekly budget of 275 euro was being spent. Considerations were made to ensure residents preferences were included in the weekly grocery shop. This weekly amount was intended to cover food for residents and staff, cleaning supplies, toiletries, administration costs and activities for residents. In addition, costs to replace light bulbs and other general day-to-day items was also coming out of the weekly budget. This was observed by inspectors on the day of the inspection.

An internal provider led audit completed in December 2024 had actions identified which included the requirement for a signed contract of care for one resident and an assessment of needs to be reviewed. All actions were documented as being completed with the date and the person responsible documented. However, an issue relating to the fire doors within the designated centre was documented in other records seen by inspectors as being ongoing since May 2024. A subsequent internal audit completed on 10 April 2025, also stated that all actions from the previous audit had been completed. However, 12 actions were identified in the most recent audit completed by the person participating in management, which included issues relating to the fire doors, financial assessment tools, safeguarding of a resident's finances, furniture and staff training.

Local management in the designated centre had highlighted during the most recent audit the requirement to provide high levels of supervision and support to some new staff members to ensure consistent approaches in-line with the assessed needs of the residents was being provided at all times. The auditor reflected that this matter would be further discussed with senior management. Not all staff had attended or were scheduled for training that was mandatory when working in this designated centre. For example, in-person staff training in the area of safeguarding had not been completed by all members of the staff team and the inspectors were informed the provider was unable to fulfill/schedule this training at the time of the inspection.

As already mentioned in this report, inspectors were only able to review records that commenced from 1st January 2025 as all other records were archived in the provider's office in another location. This directly impacted the inspectors being able to establish the length of time some concerns were being raised by staff members to the provider. These included weekly checks on the fire doors and maintenance issues. The inspectors acknowledge they were informed by the provider during the inspection that a review of the fire doors had taken place in the days prior to the

inspection. However, no planned works to address the issues found were scheduled at the time of the inspection.

The inspectors were informed there were no documented complaints in the designated at the time of the inspection. The inspectors were informed one verbal complaint was being addressed directly by the provider's complaints officer at the time of this inspection due to the nature of the complaint further information/update was not available on the day of the inspection.

Regulation 15: Staffing

The person in charge had ensured there was an actual and planned rota in place. The inspector reviewed a selection of dates on the staff rotas from the 17 March 2025, four weeks. Staffing resources were found to be in line with the statement of purpose and the number of residents being supported within the designated centre. Changes required to be made to the rota in the event of unplanned absences were found to be accurately reflected in the actual rota.

- 12 staff worked in the designated centre, this included the person in charge, team leader, social care workers and support workers
- There were no staff vacancies at the time of this inspection. Three regular relief staff were available to ensure continunity of care being provided by familiar staf to the residents.
- Staffing levels as outlined in the residents personal plans and their positive behaviour support plans were maintained in the centre.
- Staff resources and actual hours were adapted to suit the assessed needs of the residents, with further review in progress to support one resident with their required staff resources after 20:00hrs to engage in activities if required.
- Systems were in place to ensure the skill mix was maintained, including if staff required to change a scheduled shift.
- Annual leave protocols in place assisted with planning rotas in advance.
- A supervision schedule for all staff both permanent and relief was in place for 2025. This was being managed by the team leader and person in charge and scheduled to take place every four to six weeks. 11 staff had completed supervision in January 2025 which included three new staff under the provider's probation schedule. Eight staff had completed at least three such meetings since January 2025.

It was noted by the inspectors that while the hours of work for the person in charge were reflected on the roster, the location documented was not reflective of either of the two designated centres that was under their remit. Inspectors were unable to determine the extent of the person in charge's presence in the designated centre. This was discussed during the feedback meeting.

Judgment: Compliant

Regulation 23: Governance and management

While the provider had systems in place for the oversight of the designated centre, review the quality and safety of care being provided and ensure an annual review and internal audits were being completed, further improvements were required.

- Not all actions outlined to the Chief Inspector following the previous inspection in September 2024 by an inspector of social services had been completed. For example, an action under Regulation 26: Risk management procedures, the provider had given an undertaking all staff were to receive training in positive risk taking by 15 February 2025. No staff to date had received such training or was any training scheduled at the time of this inspection.
- The provider had not demonstrated effective arrangements were in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents. While there was documented evidence of staff raising issues of concern, timely responses or actions were not evidenced to have taken place by the provider this included on the day of the inspection. For example, concerns had been raised by local management since October 2024 which included emails being sent to senior management most recently on 3 April 2025 in relation to the safeguarding of a resident's finances.
- Not all actions identified in the provider's audit of December 2024 had been adequately addressed and no action plan was documented as being in place for the most recent audit that had been completed on 10 April 2025 where 12 actions were identified. These included fire safety and premises issues as well as effective safeguarding of a resident's finances.
- The provider did not demonstrate timely and effective responses were provided regarding concerns being raised by staff in relation to fire safety within the designated centre. Ongoing issues had been raised prior to 1st January 2025, however, the inspectors were only able to review records from that date to the date of the inspection. This will be actioned under regulation 28: Fire precautions

Judgment: Not compliant

Quality and safety

The inspectors were not assured the provider adequately ensured the consistent safety of residents in relation to effective fire systems being in place in the designated centre. Fire doors in the centre were seen not to be operating correctly. One inspector saw a door being held open with a towel in the kitchen and on further inspection there was an another door being held open leading to the utility. Some fire doors had hold open devices but only two of these devices worked when checked by the inspector. Three fire doors downstairs that were checked were not closing correctly. There were doors on the first floor that appeared not to be connected to the fire alarm system and two bedroom doors were not closing properly. The fire doors were also observed to be damaged with broken pieces of trim and architrave surrounding them. Doors had gaps between the door frames both underneath and on top door which would not prevent the spread of smoke in the event of a fire. The laundry room contained a washing machine which was placed in front of an oil burner for heating. There was no assurance provided that this did not increase the risk of fire in the centre. The inspectors acknowledge that there were always two waking staff on duty each night which assisted with the timely evacuation of residents should the need arise. The provider did respond to the urgent action issued under Regulation 28: Fire precautions as required to the Chief Inspector in the days after this inspection providing updates on actions being taken to address the issues identified.

Inspectors were not assured the provider was effectively providing supports to one resident in relation to the safeguarding of their finances in line with the provider's own policy -: Residents personal property personal finance and possession policy.The policy states any issue of concern must be alerted to the person in charge immediately. The issue relating to the resident's finances were raised in October 2024 following the admission of the resident to the designated centre. The policy also outlines any issues or concerns must be raised with the Operation manager. The provider also has guidelines for staff in the current Client Financial Management Policy. This policy refers to the rights of residents and their capacity to manage their own finances. While ongoing consultations were taking place to address the issue for the resident no progress had been made at the time of the inspection. The resident was not being provided with monthly bank statements, and was unaware of what monies were being held in a savings account.

Details were provided to the inspectors outlining how the resident had limited access to their own finances. While the resident did have a bank account with a bank card which they could use, a set amount of 75 euro was made available to them each week by family representatives. This amount was used by the resident to pay for gym membership which they used twice weekly and horse ridding. Staff outlined how the resident was curtailed at times to engage in social activities of their choice due to the lack of available funds. Staff had to support the resident at times to count down how many days it would be before more funds would be available to them. Staff outlined how the resident did not have access to on-line banking on their mobile phone so therefore could not establish what money was in their account. Staff has requested a screen shot be sent to the resident's phone each week so they would know what money was in their account. This had been requested after staff had witnessed the resident becoming anxious about not being able to purchase items such as treats or tools in-line with their expressed wishes

when money had not been transferred. For example, there were no recorded expenditure for the resident between 3 and 7 March 2025 when they were in the designated centre. Staff had supported the resident to engage in activities that did not require any expenditure such as walks.

It was evident staff were supporting the resident to enjoy activities such as going to the cinema when there was sufficient finances available to them. However, the resident had yet to purchase an agreed interactive communication tool as the funds were not available to them. In addition, staff had taken the resident to pick out their preference for a fish tank. However, the resident was not supported to purchase that tank and another was provided to them. Staff had also engaged with a number of farms that were part taking in the social farming. The resident had been accepted but again they were being restricted due to the lack of available finances to commence the programme.

The inspectors were informed this resident was being supported to access an independent advocacy service at the time of this inspection.

Regulation 12: Personal possessions

The inspectors reviewed available finances records since January 2025 for both residents in the designated centre.

One resident had full access to their personal finances.They were being supported by family representatives and the staff team. Weekly records demonstrated how the resident had access to their money to purchase items that they wished to. Accounts were balanced each week to reflect expenditure and balances.

One resident did not have control over their finances. There was evidence this resident was being adversely impacted with the constraints that were in place on them accessing their personal finances. This included periods of increased anxiety when they were unsure of when they could purchase even small items like a take away hot drink. The staff team were adapting the weekly activities to best support the resident in line with their available finances. The resident did not any have access to bank statements for their bank accounts on which they were named regarding their finances. The resident was prevented from part taking in a social farming project to which they had been accepted due to a lack of available finances to pay for their place on the project.

This was not in-line with the provider's own policies and procedures regarding the management of personal finances.

However, the inspectors acknowledge that actions and steps had been taken by the local management team to seek the input of independent advocacy services for the resident in the weeks prior to this inspection. While the advocacy service had been

contacted regarding the issues being faced by the resident accessing their finances an independent advocate was yet to be appointed for the resident at the time of this inspection. There was evidence that the person in charge had ongoing conversations with all relevant parties regarding the resident's access to their finances and the supports required to be in place to assist the resident to manage their finances. However, the issue remained unresolved at the time of this inspection

Judgment: Substantially compliant

Regulation 13: General welfare and development

The residents had an extensive weekly schedule of activities which included going to the gym and horse riding. Both attended day services each weekday. They had their own dedicated transport vehicle which provided them with flexibility to engage in activities at times they wished to do so. The timetables of the day of the inspection corresponded to what they did on the day. This included a pre -scheduled on-line counselling session for one resident and a spin in the evening for the other resident who just returned with staff after the inspectors had left the designated centre at the end of the inspection.

It was evident the staff team were engaging on ongoing consultation with all parties to address the impacts that were being imposed on one resident to participate in activities in accordance with their interests and capacity. Staff endeavoured to work within the resident's available budget to ensure they were able to engage in preferred recreational opportunities when ever possible.

However, the current constraints had impacted the resident's well being on occasions when they had become anxious about available funds and being unable to participate in preferred activities until funds were made available to them. The staff team had provided support with this which included counting down the number of days or linking with the family representatives to obtain additional finances to reduce the anxiety being experienced by the resident. This has been actioned under Regulation 12: personal possessions

Judgment: Compliant

Regulation 17: Premises

The provider had not ensured the premises was kept in a good state of repair internally. There were ongoing premises issues in the centre that were identified

since May 2024 that had not been addressed, this included the window in a bathroom was not opening. This was not addressed in the provider's internal audits that had taken place since then.

Additional maintenance issues that had not been addressed by the provider included-:

- The door of the dishwasher in the kitchen had come loose and was not closing properly, the dishwasher was still operational despite this. There was also damage to the kitchen unit underneath the dishwasher.
- There were bulbs missing in the lights of the kitchen. This was being addressed by the staff team on the day of the inspection.
- The table in the multipurpose room was broken, this had been broken for some time and attempts made to repair it. The inspectors were informed during the inspection that a replacement table had been ordered.
- A couch had been identified as not being suitable to meet the assessed needs of one resident on multiple occasions since January 2025. It was not possible to wash the current fabric which was required. The inspectors were informed the provider was changing the couch by the end of April 2025 with one from another designated centre.
- The location of a second washing machine in the laundry room in front of the internal oil burner did not provide assurance that either appliance could be serviced and maintained without disruption or inconvenience to residents.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents had choice when it came to meal times. There were separate menus available to the residents with picture menus used. Resident's likes and dislikes were taken into account when planning meals. There was adequate food in the centre on the day of the inspection. It was evident that staff spent time planning what groceries that would be purchased each week to remain within budgetary constraints.

Judgment: Compliant

Regulation 28: Fire precautions

An urgent action was issued to the registered provider under this regulation. The fire safety systems within the centre were inadequate and assurances were required as to when these works will be completed. Assurances were also required by the Chief Inspector that any fire safety works to be conducted in the centre would be done to an acceptable standard and by qualified and competent contractors. The provider submitted a response which outlined actions that would be taken to address the issues identified during the inspection. These issues were-:

- Fire doors in the centre were seen not to be operating correctly.
- The door into the kitchen area and the door into the utility room were being held in the opened position by tea towels due to issues regarding the closing mechanism when the inspectors arrived in the designated centre. This resulted in obstructions being caused and ineffective closing of these doors in the event of the fire alarm being activated.
- Some fire doors had hold open devices but only two of these devices worked when checked by the inspector.
- Three fire doors downstairs that were checked were not closing correctly.
- There were fire doors on the first floor that appeared not to be connected to the fire alarm system and two bedroom doors were not closing properly.
- Some fire doors were damaged with broken pieces of trim and architrave surrounding them.
- Some fire doors had gaps under and over the door which would not prevent the spread of smoke in the event of a fire.
- The laundry room contained a washing which was placed in front of an oil burner for heating. There was no assurance provided that this did not increase the risk of fire in the centre.
- Of the records reviewed by inspectors of checks on fire doors being completed by staff since 1 January 2025, ongoing issues with doors within the designated centre had been reported by staff members. Records of checks prior to this date were unavailable for the inspectors to review on the day of the inspection.

The provider did response as required to the Chief Inspector in the days after this inspection providing updates on actions being taken to address the issues identified with time lines also provided in the responses submitted.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Both residents in receipt of services in the designated centre did have a personal plan in place. These are intended to identify the health, personal and social needs of residents while also providing guidance for staff on how to meet these needs.

The personal plans for both residents were reviewed during the inspection. The personal plans contained background information on the residents, including their

likes and dislikes. The personal plans were found to contain assessments and health care plans which were reflective of up-to-date information relating to both residents. These were found to have been reviewed regularly as required or at a minimum every six months. They also contained goals relevant and suitable for each resident. Regular reviews of such goals were taking place at a minimum every three months and progress on attaining or achieving the goals were being documented. Review meetings had taken place with families and the residents had achieved the majority of their goals planned up to this time of the year. Other goals were being discussed with residents for the rest of the year. Goals were being reviewed on a quarterly basis.

However, as previously mentioned in this report, one resident had not been supported by the provider to attain a personal goal in 2024 to go on a holiday. This will be actioned under Regulation 9: Resident's rights.

Judgment: Compliant

Regulation 7: Positive behavioural support

Specific support plans were available for staff which provided guidance and information on how to encourage residents to engage in positive behaviour. An inspector reviewed two of these plans and noted that they contained a good level of information around supporting residents in this area. Staff spoken with demonstrated a good awareness of the contents of these plans. This included guidance for staff to work with the residents when they displayed behaviour of concern. There were also visual aids throughout the centre that assisted the residents to create and view their schedule throughout the week.

One resident had been accepted to re-engage with an external behavioural support specialist team due to a recent change in their assessed needs and presentation. The other resident was actively engaging in weekly on-line sessions with a behaviour support specialist which was part of an action plan following the presentation of behaviours in October 2024. The specialist met with the resident in person for the first session and seven sessions had taken place up to and including on the day of the inspection. A total of 15 sessions were planned and staff reported these were working well for the resident. Staff also found the information being provided helpful to assist them in consistently supporting the resident.

It was documented for one resident in their behaviour support plan the benefits of engaging in social farming. This had not been attained due to barriers relating to their finances. This will be actioned under Regulation 12: Personal possessions.

Judgment: Compliant

Regulation 8: Protection

Personal and intimate care plans were clearly laid out and written in a way which promoted residents' rights to privacy and bodily integrity. There was also easy to read information for one resident pertaining to their routine and how staff supported them while maintaining their privacy.

A recent change to the assessed needs of one resident in relation to their intimate care needs was being monitored by the staff team to ensure the resident was being provided with all the required supports including access to allied health care professionals if required.

Residents were provided with information in a suitable format and supported to be aware of safeguarding at their key working meetings.

However, the inspectors were informed that not all staff had attended appropriate training in safeguarding of vulnerable adults at the time of this inspection. The social care leader and person in charge had informed the provider's training department of the requirement for this training to be provided to new staff members via emails in the weeks prior to this inspection. The social care leader had received a response from the training department that the provider was unable to fulfill this requirement as no trainer was available. There was no safeguarding training scheduled for those that required it at the time of this inspection. This will require further review by the person in charge

Judgment: Substantially compliant

Regulation 9: Residents' rights

Each resident had access to a dedicated vehicle which enabled them to attend their activities and provided flexibility in their daily routines. These vehicles were been used throughout the day of the inspection.

The provider had not ensured that one resident had been supported to participate in decisions being made about their care and supports. This included restricted access on their mobile phone which limited access the internet at certain times and were curtailed in what they could view due to controls placed on the settings by family representatives. While the rationale for these controls were provided to the inspectors these controls were not put in place by the provider, allied health care professionals or staff team. The inspectors were unable to establish if the voice of

the resident had been considered in reviewing this restriction on admission to the designated centre or in the months since then up to the time of this inspection.

Residents were unable to go on a Christmas holiday in December 2024 as planned with them as the provider stated there were insufficient funds for staff to support them on this trip. Another holiday was planned for 2025, this required the staff to give options to the senior managers in the organisation. The staff team had been informed that the provider would choose the location of the holiday. This meant that the residents would not be able to go on a trip to a location of their choosing.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Leamlara Residential Service OSV-0008052

Inspection ID: MON-0046844

Date of inspection: 16/04/2025

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: An urgent compliance plan has been submitted to HIQA. Online positive risk management training has taken place, this will be completed by the end of June 2025. Staff have been reminded of their duty to raise issues and concerns and a new PPIM is in place for the centre. A new PIC is due to start on 3rd June and escalation of concerns will be included within their induction. A new process is in place for raising serious risks directly with the registered provider. A new Quality and Audit Officer has joined the company, they will be completing health and safety reviews of all registered services as part of their work. Works related to fire safety are currently being undertaken and a new audit will be completed by the PPIM once works are completed (before the end of June 2025).	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: The issue regarding residents not having control over their finances has now been fully resolved. The resident now has full access and is able to spend their money as they wish.	

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A temporary maintenance officer is now in place which has resulted in works being checked to ensure that they are completed to a high standard. All maintenance issues have now been resolved, the washer has been relocated.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: An urgent compliance plan has been submitted to HIQA. All issues with the fire doors have now been resolved and the washing machine has been moved. A temporary maintenance officer is now in place which has resulted in works being checked to ensure that they are completed to a high standard.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Additional safeguarding training has taken place for the staff, with further training due to take place on 23rd May. Information regarding staff training is now available on the One touch scheduling system, allowing the PIC and Deputy Manager to easily see when someone's training is due to expire and ensure they are put on refresher training.	
Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Restrictions on the use of internet by a family member has now been resolved. Issues with the holiday have been in relation to staffing levels for the proposed trip due to an increase in staffing levels for one client as a result of a serious incident. Full staffing levels are now in place. Arrangements have been made for a holiday in June 2025 at a location of the clients choosing. This has now been booked.	

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/07/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	20/06/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Substantially Compliant	Yellow	31/07/2025

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/07/2025
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	31/07/2025
Regulation 28(1)	The registered provider shall ensure that	Not Compliant	Red	18/04/2025

	effective fire safety management systems are in place.			
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Red	18/04/2025
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	18/04/2025
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	31/07/2025
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and	Not Compliant	Orange	20/06/2025

	consents, with supports where necessary, to decisions about his or her care and support.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/07/2025
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights.	Substantially Compliant	Yellow	20/06/2025