Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Lios Mor
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	17 July 2025
Centre ID:	OSV-0004745
Fieldwork ID:	MON-0047717

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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 17 July 2025	09:35hrs to 18:05hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Much of the inspection day was spent in the larger building of this centre where the atmosphere was found to be quiet. All residents present in the centre on the day of inspection were met or seen but verbal interaction with some residents was limited. Staff on duty were noted to be pleasant in their interactions with residents.

This designated centre was registered for a maximum capacity of 11 residents and was made up of a larger building which provided a home for 10 residents and a smaller building for one resident. Both buildings were located beside one another on the same grounds. At the time of the inspection 10 residents in total were living between both the larger building and the smaller building with there being one vacancy in the former. One of the ten residents living in the centre was in hospital on the day of inspection and so was not met by the inspector. He did met or see the remaining nine residents who were all present with the inspector spending the majority of the day in the larger building.

On arrival there to commence the inspection, the inspector was let into the building by a member of staff who directed the inspector to sign into a log. The inspector did so but noted when doing so that staff on duty who had already signed into the same log had already indicated a sign out time for later in the day. After signing in, the inspector did an initial walkthrough of the building with some residents either still in bed or being supported with personal care while other residents were in communal areas receiving breakfast. The inspector greeted some of these residents at this time with one of them smiling at the inspector. It was apparent at this time that staff on duty were busy in supporting residents.

The atmosphere during this initial walkthrough was quiet and staff were heard to be pleasant in their interactions with residents. For example, one staff member asked residents how they were. Another staff member was seen supporting one resident with their breakfast which they did in a warm and unhurried manner. As they were supporting this resident with breakfast, this staff member also made small talk with another resident by talking to them about the weather. The inspector greeted more residents at this time with one of them indicating that their breakfast had been nice. When the inspector asked if the resident would be going out later, the resident indicated that they would not because of the rain.

During the initial walkthrough of the larger building, which overall was seen to be clean and well-furnished, the inspector noted that the building had multiple fire exits including directly from residents' bedrooms. However, while the majority of such exits were seen to be unobstructed, the inspector did observe that identified exit routes from one corridor and though the building's laundry room were partly obstructed. The inspector also noted an external contractor arrived at the larger building and signed into the log present but entered a different time to the time they actually arrived in the building. Such observations were highlighted to

management of the centre.

As the morning of the inspection progressed, the inspector was informed that one resident in the larger building and the resident in smaller building, had the left the centre to go to day services. However, the inspector was also informed that two other residents were meant to go day services where a summer party was being held but could not attend. It was indicated that this was because both residents used wheelchairs and needed staff support from the centre to attend but that such staff support was not available on the day of inspection. Further discussions and documentation later reviewed, indicated that this was not an isolated occurrence and will be returned to later in this report.

Of the seven residents that remained in the larger building, most of these appeared to spend much of the day in the communal areas of the building. The inspector did greet such residents but most residents did not interact with the inspector. One of these residents again smiled at the inspector and indicated that they had had a nice breakfast while another resident mentioned having tea. At one point the seven residents were present in communal rooms of the building, when two staff supported one resident to get up and mobilise towards their bedrooms. Because of this the six remaining residents were left unsupervised for a brief period. During this period one resident mentioned the name of a nearby town with another resident responding by telling the resident that they were not going to this town.

The inspector spent much of the early afternoon of the inspection reviewing documentation in the staff office of the larger building. The atmosphere in the building at this time continued to be quiet although some recent incident reports read did reference a resident who could scream and shout. Later in the afternoon, the relatives of one resident arrived at the building to mark the resident's birthday. It was seen that the resident went with their relatives towards the resident's bedroom. Other residents remained in communal areas while staff prepared them meals and also put up some happy birthday signs. The resident from the larger building who attended day services, returned around this time and was greeted by the inspector. The inspector left this building soon after and as he did so, it was noted that the atmosphere continued to be quiet with most residents in communal areas of the building with staff present.

After leaving the larger building, the inspector briefly visited the smaller building where the resident living there had also returned from day services. Prior to a feedback meeting for the inspection, the inspector met this resident in the presence of a staff member and a member of management. This resident greeted the inspector who asked the resident how they were doing. The resident responded by saying "okay". The inspector asked the resident how long they had been living in their current home with the resident looking at the staff member present. The staff member informed the inspector that the resident had moved in the previous summer.

The inspector then asked if the resident liked living in their home with the resident answering "yes" to this. When asked what they liked about living there, the resident appeared to indicate that they liked the chair they were sitting on at the time. The

member of management present, then highlighted how the resident had gone to the summer party in day services earlier in the day. The staff member also mentioned how the resident had done some recycling the previous day. The resident was asked what they would be doing later in the day but the inspector could not make out the resident's response. As a meal was being prepared for the resident at the time, the inspector then conducted the feedback meeting with the member of management. After this he returned to the resident's living area to say goodbye to the resident who responded in kind.

In summary, two of the residents left the centre during the day to attend day services but the remaining residents appeared to spend much of the day in communal areas of the larger area of the centre. Meals were seen to be prepared for residents in the centre by the staff on duty who were observed and overheard to interact appropriately with residents. Direct feedback from residents was limited but two did indicate they had nice breakfasts while another said that they liked living 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

Some specific oversight measures previously committed to were in place. Staffing challenges were found during this inspection which were impacting residents. Issues were found on this inspection relating to required notifications.

This centre was registered until January 2027 and had last been inspected on behalf of the Chief Inspector of Social Services in July 2024. That inspection found some regulatory actions in areas such as medicines, complaints and staffing while the content of a provider unannounced visit report provided in the days following the inspection caused some concern. The nature of such concerns prompted the Chief Inspector to seek additional assurances related to oversight which was reflected in the July 2024 inspection report. The provider's compliance plan response submitted in response to that inspection was accepted. Since then, a notification received from the centre of an alleged safeguarding matter that also caused concern, particularly given previous practice and safeguarding concerns that had been identified during two 2023 inspections of the centre. The Chief Inspector sought further assurances on this allegation which were provided. At the time of the current inspection, this safeguarding allegation was still in the process of being investigated.

While the outcome to this investigation was awaited, the current inspection was conducted primarily to focus on the area of safeguarding generally. As will be discussed further elsewhere in this report, some areas in need of improvement were found in this area while the initially intended focus of this inspection was slightly

changed so that Regulation 31 Notification of incidents could be included in the report. This was done as it found that not all incidents occurring or allegations being raised were being appropriate notified. Such incidents had been previously notified as safeguarding incidents but had not been more recently. It was acknowledged though that management of the centre were aware of the impact that this resident was having and of staffing challenges that were impacting residents. Both of these had been, or due to be, escalated in line with the provider's processes in this area. Some specific oversight measures that the provider had previously committed were found to be in operation during this inspection.

Regulation 15: Staffing

During the July 2024 inspection, it had been identified that some residents had been complaining about staff shortages that were impacting their ability to leave the centre. In addition, that inspection also found that additional staffing support for the centre between 8pm and 10pm, which had been approved to meet the needs of one resident, was not always in place for these hours. On the current inspection, rotas were reviewed from 1 June 2025 on which again showed that that the additional staffing support for the centre between 8pm and 10pm was not always in place. The inspector was also informed that a risk had been escalated within the centre related to staffing in the centre during May 2025. A copy of the risk assessment and reviews of this risk were provided to the inspector.

These documents indicated that on account of changing needs of residents in the centre that there was a risk that a large amount of staff time would focus on providing basic care needs which could impact residents' quality of life. In support of this it was highlighted how five residents, who received activation from the centre, had very limited access to social outings in 2025. Examples were given from April and May 2025 where some of these residents had zero social outings. Discussions with staff members on this inspection, confirmed that there were still occasions occurring where residents' abilities to leave the centre were being adversely impacted due to staffing. For example, as referenced earlier in this report, the inspector was informed that two residents were unable to attend a summer party on the day of inspection as there was not enough staff support available from the centre. It was acknowledged that a contributory factor to this matter was an increase in the health and mobility needs of some residents in the centre.

As a result, some residents needed more help to mobilise or with hoisting. In particular, it was highlighted that one resident's dementia had progressed since the previous inspection with this resident now requiring the support of three staff for hoisting. The increased health needs of residents, which was also reflected in an increase in hospital admissions for residents, resulted in some staff being assigned to these residents to support them while in hospital. In turn this reduced the number of staff working in the centre on certain days including the day of inspection. The staffing challenges impacting residents were known to management of the centre and the inspector was informed that measures were being taken to

ease pressure on staff, such as increasing cleaning hours from an external company. However, the evidence gathered during this inspection indicated that, at the time of inspection, the staffing arrangements in the centre were not supporting residents' social needs.

Judgment: Not compliant

Regulation 16: Training and staff development

A staff training matrix provided during the inspection indicated that the majority of staff had completed relevant training to support the needs of the residents. This included all staff having completed safeguarding training with staff members spoken with during this inspection demonstrating a good knowledge in this area. It was noted though that some staff were overdue refresher training. For example:

- Two staff were overdue refresher training in manual handling.
- Five staff were overdue refresher training in safety intervention.
- One staff member was overdue refresher training in fire safety.

A further two staff member were indicated as not having completed manual training but the matrix indicated that these staff were booked to receive this training. During the feedback meeting for the inspection, it was indicated to the inspector that some staff had been unable to complete some trainings as they had been required to support some residents while they were in hospital.

Aside from staff training, the inspector was informed that staff supervision was to be done quarterly. While no individual staff supervision records were presented during the inspection, comments of the person in charge on the day suggested that not all staff had received timely supervision. Communication received following this inspection confirmed that supervision was not up to date for the first two quarters of 2025 with 23 staff not receiving formal supervision in a timely manner. It was indicated that this was contributed to by two clinical nurse managers (who provided supervision to some staff), not receiving office days and being required to work on the floor for assigned office days. This was related to staffing challenges brought about by staff from the centre having to support residents in hospital as discussed under Regulation 15 Staffing.

Documentation that was present in the larger building of the centre on the day of inspection included copies of relevant regulations, national standards related to disability services and safeguarding guidance documents. Under this regulation, copies of these must be made available to staff members.

Judgment: Not compliant

Regulation 23: Governance and management

Information given on the day of inspection and communication received in the days following inspection confirmed that some specific oversight measures for the centre previously committed to were in place. These included:

- Members of management of the centre making unannounced visits to the centre every month at varied times. However, it was noted that the provider had previously committed to making three such unannounced visits per month but from a log of visits provided for 2025, the frequency of these had decreased to one or two a month.
- Quarterly meetings between management of the centre and senior management of the provider to review the centre (the inspector was informed that notes of these meetings were not recorded but dates as to when they happened were provided).
- The maintenance of a tracking document to track progress on actions identified. The inspector was informed that this tracking document was discussed with senior management during quarterly meetings.

Given the concerns that had been raised by the provider unannounced visit report provided in the days after the July 2024 inspection, the provider had also committed to introducing a formal internal system of escalation related to the findings of such unannounced visits. When the inspector queried this with local management of the centre on the current inspection, there was uncertainty as to this systems. As such the inspector requested further information about this. In the days following inspection it was indicated that the person in charge had requested an update in relation to this which would be submitted to the inspector.

Since the July 2024 inspection, two provider unannounced visits had been carried for the centre by a representative of the provider. Under the regulations, such unannounced visits must be carried out at least once every six months. From the reports of the two provider unannounced visits done, it was seen that the first had been done on 3 December 2024 and the second on 23 June 2025. As such there had been over six months between these visits. A similar issue around the timeliness of provider unannounced visits was highlighted by the July 2024 inspection also. It was acknowledged that the draft report of the June 2025 provider unannounced visit was found to be detailed in nature and assessed relevant matters related to the quality and safety of care and support provided to residents. For example, it highlighted similar staffing concerns to those identified by the current inspection.

Other than provider unannounced visits, an annual review for the centre had been completed in March 2025 which assessed the centre against relevant national standards and provided for consultation with residents and their representatives. When reading a report of this annual review, it was noted that such feedback was positive. During the inspection, the inspector also reviewed a copy of a safeguarding self-assessment that had been completed in April 2024 and which was marked to be completed again in April 2025. However, when the inspector queried this with the person in charge, he was informed that it had not been done. It was also identified

on this inspection that the review of certain incidents in the centre had been impacted by matters related to annual leave and unexpected circumstances. Such incidents will be discussed further in the context of Regulation 8 Protection but this did raise a concern around review of such incidents when the person in charge was absent. It was acknowledged though that there had been some recent temporary management changes impacting the centre and the provider which were related to unforeseen events. In addition, as referenced under Regulation 15 Staffing, there were staffing issues impacting the centre which was impacting compliance in other regulations. While the provider was aware of such issues, it had yet to sufficiently address them at the time of inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

A copy of the statement of purpose for the centre was provided during this inspection. This was dated October 2024 and contained much of the information required under the regulations. These included details of the organisational structure for the centre and the arrangements for residents to attend religious services of their choice. However, while the statement of purpose did include some details around the staffing arrangements in place for the centre, the inspector was informed that the statement of purpose required updating to reflect some changes in staffing in more recent times.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

In keeping with this regulation, the Chief Inspector must be notified of matters of a safeguarding matter within three working days. Since the July 2024 inspection, eight such notifications had been submitted from this centre. The majority of these were submitted in a timely manner. However, one safeguarding matter notified has been raised internally and reported on 22 February 2025 but was not notified to the Chief Inspector until 24 March 2025. As such, the requirements of this regulation had not been complied with.

Another safeguarding matter had been notified to the Chief Inspector on 22 January 2025 with the notification form submitted detailing a particular allegation that had been made. However, following this inspection, documentation was provided around this allegation which indicated that some additional concerns had been raised just prior to the notification being submitted. The nature of these additional concerns had not been included in the notification submitted to the Chief Inspector on 22

January 2025.

Furthermore, as will be discussed further in the context of Regulation 8 Protection, the presentation of one resident had negatively impacted other residents recently. No recent safeguarding notifications about this had been submitted even though they had been previously submitted in the past.

Judgment: Not compliant

Quality and safety

Weekly residents' meetings were used to discuss matters as complaints and safeguarding. Some safeguarding matters had been processed through safeguarding processes but residents being negatively impacted by another had not.

Residents had personal plans in place which provided guidance on how to meet their needs. This included guidance on how to support residents to engage positive behaviour but given the content of some incident reports, the inspector had to request a copy of the documented guidance related to a particular approach that was indicated as being adopted with one resident. Other incident reports reviewed also referenced some residents being negatively impacted by the presentation of one resident. These were deemed not to be safeguarding concerns even though previous instances in the past had been deemed as such and a red rated (high) risk had been assessed related to the impact of this resident on their peers. Documentation was provided that other safeguarding matters had been considered through safeguarding processes in accordance with relevant safeguarding policies. Safeguarding was indicated as being discussed as weekly residents' meetings that were taking place consistently in the centre over recent months. Other matters such as menus and complaints were also indicated as being discussed at such meetings. One complaint recorded on behalf of a former resident indicated that there had been a delay in the resident accessing their own money.

Regulation 10: Communication

Personal plans reviewed contained some information on how to communicate with residents. However, when going through the personal plan of one resident, one document reviewed in this indicated that the resident did not have a communication passport. This was despite notes of two multidisciplinary meetings from 2024 both including an action for a referral to be made to a speech and language therapist (SLT) for the purposes of developing a communication passport. The time frame for both of these actions was given as one month. As such, on the inspection day, the inspector queried if the resident had a communication passport in place with such passports providing additional guidance on how a resident communicates. No

communication passport for the resident could be located on the day of inspection while those present were also unsure as to the status of an SLT referral. Communication received following the inspection confirmed that the resident did not have a communication passport. It was also indicated that the SLT referral had "just been sent".

Judgment: Substantially compliant

Regulation 13: General welfare and development

Some of the residents of this centre attended day services away from the centre while others were to be activated from the centre. During the July 2024 inspection, it was found that some residents who attended day services were complaining about their access to day services. While such matters were contributed to by staffing issues in the day services, which was not under the remit of the Chief Inspector, the issues around day services were impacting residents' abilities to participate in activities in accordance with their interests. Complaints records reviewed on the current inspection also indicated that some residents had continued to complain about accessing day services. This again related to staffing issues in the day services but also staffing matters in this designated centre as discussed under Regulation 15 Staffing. Such staffing issues were also impacting the ability of residents who did not attend day services away from the centre to participate in social outings. As such, it remained the case at the time of the current inspection that residents' abilities to participate in activities in accordance with their interests was being adversely impacted.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The personal plans of two residents were reviewed during this inspection. These were found to have been recently reviewed and were the subject of multidisciplinary review while also providing guidance on meeting the needs of residents. A process of person-centred planning for residents was also being followed which was used to identify goals for residents to achieve. Documentation reviewed related to this indicated that residents and their families were involved in this process while goals identified for residents were also documented in an easy-to-read format. Such matters were in keeping with the requirements of this regulation.

It also required under this regulation that arrangements are in place to meet the assessed health, personal and social needs of residents. As highlighted earlier in this report, the needs of some residents had increased from a health and mobility needs perspective. While support was being provided to residents with these, residents'

social needs were not being adequately met at the time of inspection. This is reflected under Regulation 13 General welfare and development and Regulation 15 Staffing.

Judgment: Compliant

Regulation 7: Positive behavioural support

A training matrix provided indicated that all staff had completed training in safety intervention which was relevant for de-escalation and intervention techniques. Five staff members were overdue refresher training in this area but this is addressed under Regulation 16 Training and staff development. Aside from this, when reviewing incident records in the centre it was seen that one resident could present in a certain way with the incident records indicating that staff followed a positive behaviour support plan for the resident in response. The inspector reviewed a copy of this positive behaviour support plan and noted that it outlined strategies for staff to adopt to support the resident to engage in positive behaviour.

Two other recent incidents reports were also read where reference was made to a resident presenting with behaviour that challenges during personal care and being given a "timeout" by the staff supporting them at the time. One of these incidents reports appear to suggest that the resident was given "a two minute timeout" while sitting on the toilet and that the staff did this having been advised to do so by another member of staff. The inspector sought a copy of the guidance document or support plan related to this approach. Following the inspection it was indicated that the resident did "not have a support plan that references being given a 'time out' and the use of this language is unfortunate and inaccurate". In light of this, the knowledge of staff for supporting this resident needed review.

Judgment: Substantially compliant

Regulation 8: Protection

Since the July 2024 inspection, the Chief Inspector had received notification of eight safeguarding matters from this centre. One of these related to an alleged safeguarding matter that caused particular concern. This allegation was still being investigated at the time of this inspection. Documentation provided to the Chief Inspector shortly after this allegation was first raised had confirmed that this matter had been referred to the Health Service Executive (HSE) Safeguarding and Protection Team in keeping with relevant safeguarding policies. During this inspection process, similar documentation was provided for the other seven safeguarding matters which also confirmed that these had been referred to HSE Safeguarding and Protection Team. However, for one of these matters it had been

highlighted that there was delay in referring this to the HSE Safeguarding and Protection Team. It was confirmed that this was related to annual leave for the person in charge and the provider's designated officer (person who reviews safeguarding concerns) at the time it arose. The inspector was informed that measures had been introduced to prevent such delays from occurring again.

Amongst the safeguarding notifications that had been received since the July 2024, two involved instances of unexplained bruising. Based on incident records reviewed, some instances of unexplained bruising were being reported as incidents and reviewed by the person in charge. When reviewing such incident records, it was seen that after person in charge review for some of these, possible reasons had been put forward for the initially unexplained bruises and so these were not deemed to be safeguarding concerns. The inspector did note though two recent incident reports where residents were indicated as having unexplained bruises. These incidents had not been reviewed by the person in charge so it was unclear if these had been considered from a safeguarding perspective. It was acknowledged by the person in charge that they had not reviewed some recent incident reports in the centre owing to annual leave and unexpected circumstances.

Of the safeguarding notifications that had been received since the July 2024 only one related to an incident where a resident had impacted another resident. Some such incidents had been notified during 2023 and 2024 with safeguarding plans in place related these. Such safeguarding plans outlined measures to prevent reoccurrence including staff supervision. Despite this, during the inspection, one brief instance was observed where six residents was left unsupervised including residents whom safeguarding plans related to. No adverse incident was observed during this brief period although it was noted that two residents did have a verbal exchange during this time. The vocalisations of one of these residents had impacted other residents in 2023 and 2024 based on previous notified incidents.

When reviewing incidents records, the inspector read some recent incident reports where the presentation of this resident was indicated as impacting their peers. Such incidents involved the following:

- In one incident the resident was described as "vocal+++" from shouting and screaming and that two residents had complained about this with one resident saying they had a headache and the other getting agitated.
- Another incident occurred late at night where the same resident started to talk to themselves that prompted another resident to shout "shut up".
- A third incident described how the resident started shouting and screaming very loudly with all residents moved elsewhere except for one resident. This resident later requested to move elsewhere due to the screaming of their peer.

All three incidents had been reviewed by the person in charge. Such reviews indicted that a safeguarding plan had been followed and these incidents had raised with the designated officer and deemed not be safeguarding. Despite this, it was acknowledged within the centre thought that there was an impact on other residents from the resident involved which was reflected in a red rated risk assessment that

was due to escalated internally with the provider. The documentation around this made reference to considering whether a different living environment might be more suitable for the resident who was screaming and shouting. Taking into account the incidents described above and the previous incidents from 2023 and 2024, there were negative impacts which were not being processed through safeguarding process. It was also noted that even though reference was made to safeguarding plans being followed, this did not prevent residents being adversely impacted.

Judgment: Not compliant

Regulation 9: Residents' rights

Notes of residents' meetings occurring in the centre were reviewed from 5 April 2025 until 12 July 2025. These indicated that such meetings were occurring consistently on a weekly basis although staff members spoken with did indicate that some residents engaged with these meetings more than other residents. The meeting notes did indicate that residents were being given information in areas such as safeguarding, menus and activities with notes from 6 July 2025 indicating that residents had been informed about some recent management changes for the centre.

It was also seen that these meetings gave resident an opportunity to raise complaints. When reviewing complaints records for the centre, it was seen that one complaint had been made on behalf of a former resident on 30 November 2024 by a staff member. This indicted that the staff member had requested money from the resident's bank account, on the resident's behalf, in September 2024 but was still waiting on this. This meant that, at the time the complaint was made, the resident has been unable to do some shopping. This complaint was marked as being resolved on 18 December 2024 and it was stated that the resident had received their money and had been able to go shopping.

When queried with the person in charge, it was acknowledged that there had been a delay in processing the request for the resident's money. This was related to the type of bank account which the resident had which required requests for the resident's money to be approved by two members of management before being sent to the bank for processing. The inspector was informed that most current residents had the same type of bank account. The processes followed for these limited residents' access to and control over their own finances. As such this impacted residents' legal rights.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Lios Mor OSV-0004745

Inspection ID: MON-0047717

Date of inspection: 17/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Currently there are 2 nurses and 2 HCAs onboarding and going through HR processing. A relief staff nurse for West Limerick is being recruited currently. • Recruitment ongoing for twilight hours. • Filling vacant bed in Liosmor is on temporary hold, pending stabilization of staffing levels. • A quality of life risk assessment was developed on 19/05/2025 with a number of additional controls identified as being required to mitigate against the impact of changing needs and hospitalizations on the ability of staff to support activities. Additional controls identified included outsourcing of meal prep, increasing laundry service to include person supported laundry in addition to bed linens and towels, deep clean to be arranged quarterly to reduce the cleaning burden on support staff, booking of external transport for appointments to reduce the number of staff who need to support appointments, the recruitment of a staff on a 0/78 basis to cover leave (the usual requirement for a driving license not to apply to aid recruitment). • This risk was reviewed at the escalated risk clinic on 06/06/2025 where the DOS approved all proposed additional mitigations to be progressed. • The risk was reviewed again at the escalated risk clinic on 08/08/2025. As of that time a number of the additional mitigations (outsourcing of laundry, quarterly deep clean and external transport for appointments) have been progressed. Engagement has commenced to organize for outsourcing of meal prep. Recruitment of 0/78 contract is pending. • Once all agreed mitigations have been progressed the risk will be reviewed again to consider if the risk rating has reduced to an acceptable level. If this is not the case additional mitigations required will be agreed and progressed • Management is actively reviewing staffing levels and rostering to better align with residents' changing needs and is exploring different measures to mitigate staffing shortages and enhance residents' social needs. • A new transport vehicle has been approved for the designated Centre, which will facilitate 2 wheelchair users to travel at the same time. This will enhance the residents' ability to attend social outings, where transport otherwise might be a barrier.	

• Shift planner in place, will be reviewed with a view to ensuring opportunities for social engagement. • Shift planner will be discussed with staff team at the monthly team meetings.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• 1 staff out of date in Manual Handling have been booked for upcoming training. Of the other staff identified as being out of date, 1 staff is on long term leave since 01 Feb 2025, 1 staff no longer works with the service and the other staff is on pregnancy related leave and will commence maternity leave immediately afterwards. These staff will be prioritized for manual handling training upon their return to duty. The training matrix has been updated to reflect same.

• Having reviewed the training matrix there were five staff out of date with Safety Intervention. Of these staff, 3 staff have been booked for refresher training. Of the remaining staff identified as needing refresher training, 1 of these staff is on Maternity Leave and the other staff is on long term leave since April 2024.

• Staff who was out of date with fire training had been booked for training in July but had to be cancelled to support a resident in hospital. This training has been rebooked for August 2025.

• The PIC, Area Manager and CNM1s have met to discuss the supervision schedule. A monthly email will be sent by the PIC to the Area Manager with planned and completed supervision.

• All staff supervisions for Q3 will be completed by 31st September 2025 and all staff supervisions for Q4 will be completed by 31st December 2025.

• Copies of relevant regulations, national standards related to disability services and safeguarding guidance documents will be made available to staff.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• CNM1s on night duty commenced on 19th May 2025 to provide governance on nights.

• Area Manager, PIC and HOCS will continue to carry out monthly unannounced visits once a month.

• PIC shift pattern includes 3 shifts 11.30-22.30 each fortnight as part of on-call roster.

• In the event that an internal 6-month review is raised as a particular concern by the person conducting the review with the Head of Quality Enhancement and Training due to a high number of significant non-compliances the Head of Quality Enhancement and Training communicates this to the Director of Services and Head of Services in order to highlight that a priority review of the report is required by the governance team. In situations where this occurs the person conducting the review reflects this engagement and escalated communication in the 6-month review report.
• Unannounced provider inspection will be carried out prior to 23rd Dec 2025 to ensure that it is completed within the six-month timeframe.
• Safeguarding self-assessment will be completed and will be reviewed within the required timeframe.
• In the Absence of the PIC the CNM1 on duty will review and authorize AIRS.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Statement of purpose will be updated to reflect current staffing changes.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All adult safeguarding referral's will be notified to the regulator within 3 working days as per regulation.
• It is acknowledged that some of the information viewed by the Inspector in the Preliminary Screening document was not contained in the NF06. Any information that was omitted was deemed as not relevant to the notification of abuse due to it being opinion rather than fact and potentially defamatory in nature. There was no intention to mislead the Inspector.
• In future, the PIC can forward the preliminary screening following the return of the NF06 to the Inspector while the notification is in progress if requested.
• The Designated Officer is available to the inspector for further clarification if required.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• Referral was sent to SLT for Communication Assessment for resident on 18/07/25.
• Following consultation with SLT, template was provided for a communication passport which the keyworker will complete.
• Keyworker will also develop a communication dictionary for resident based on phrases she uses and how staff should respond.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• A weekly activity planner is in place to afford all residents equal opportunity to access social outings.
• Shift planner in place, will be reviewed with a view to ensuring opportunities for social engagement.
• Shift planner will be discussed with staff team at the monthly team meetings.
• In House activities are carried out weekly, music therapy, pet therapy and Arts and Crafts.
• In the event that social outings are cancelled due to staffing levels, planner will be reviewed with a view to rescheduling the activity.
• Contingency planning for staffing will be utilized in the event that there is not adequate staffing to facilitate social outings due to staff shortages or additional staffing requirement needed to support hospitalizations.
• Currently there are 2 nurses and 2 HCAs onboarding and going through HR processing. A relief staff nurse for West Limerick is being recruited currently.
• Recruitment ongoing for twilight hours.
• Filling vacant bed in Liosmor is on temporary hold, pending stabilization of staffing levels.
• A quality of life risk assessment was developed on 19/05/2025 with a number of additional controls identified as being required to mitigate against the impact of changing needs and hospitalizations on the ability of staff to support activities. Additional controls identified included outsourcing of meal prep, increasing laundry service to include person supported laundry in addition to bed linens and towels, deep clean to be arranged quarterly to reduce the cleaning burden on support staff, booking of external transport for appointments to reduce the number of staff who need to support appointments, the recruitment of a staff on a 0/78 basis to cover leave (the usual requirement for a driving license not to apply to aid recruitment).

• This risk was reviewed at the escalated risk clinic on 06/06/2025 where the DOS approved all proposed additional mitigations to be progressed.
• The risk was reviewed again at the escalated risk clinic on 08/08/2025. As of that time a number of the additional mitigations (outsourcing of laundry, quarterly deep clean and external transport for appointments) have been progressed. Engagement has commenced to organize for outsourcing of meal prep. Recruitment of 0/78 contract is pending.
• Once all agreed mitigations have been progressed the risk will be reviewed again to consider if the risk rating has reduced to an acceptable level. If this is not the case additional mitigations required will be agreed and progressed.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• PIC spoke with staff member in question on 23rd July 2025 and clarified the meaning of the language he used in the AIRS. Discussion took place around appropriate use of language and clear and concise reporting.
• Site specific training will be provided for staff member in behavior support and report writing.
• Use of language training will be completed by staff member in relation to incident reporting.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The BOCSILR has a zero tolerance to abuse in line with the BOCSI Policy on the Safeguarding of Vulnerable Adults at risk from abuse.
• The focus of the zero tolerance approach is to ensure all concerns deemed to meet the definition of abuse as set out in the HSE Safeguarding Vulnerable Adults at risk of abuse policy 2014, are considered and assessed appropriately.
• Each incident is considered individually by the authorizing manager on review of relevant AIRS report. In the event that support is required to consider if an adult safeguarding referral is indicated, the designated officer is contacted to discuss the individual incident and consider if it meets the definition of abuse.
• There were 2 prior incidents (2023 and 2024) notified to the Inspector and to the HSE Safeguarding and Protection Team relating to vocalization. Of these the first was returned as "reasonable grounds" and the second was returned on "no grounds" on

further assessment. This finding was agreed by the HSE Safeguarding and Protection Team.
• It was on this basis of further assessment and on engagement with the Adult at Risk of Abuse that these incidents did not meet the definition of abuse and were more appropriately managed via risk management and complaints processes.
• The incidents in 2025 that relates to the resident who vocalizes loudly when she is in pain and distress, were considered by the PIC and one of these incidents was discussed with the Designated Officer who noted that the incident did not appear to meet the definition of abuse as the resident was not shouting at her peers or threatening them and there was no intent to cause harm. Neither is there any lasting impact on the person's supported. People supported choosing to move to a different space is not in and of itself indicative of abuse. The risk assessment was none the less forwarded to the Head of Quality Enhancement and Training for consideration at the escalated risk clinic on 08/08/2025.
• The Head of Quality Enhancement and Training requested a meeting with the PIC and Designated Officer. The meeting took place on 12/08/2025. It was agreed that the risk description and categorization, as developed on 06/08/2023, are not an accurate reflection of the current situation. The risk assessment was closed and new risk assessment is in development. Consideration was given to whether the risk category should remain Harm to Person.
• Based on an awareness of incidents in 2025, it was agreed that while peers may express frustration in the moment, express a wish to move to another space or express the wish to make a complaint, there is no evidence of distress or psychosocial impact. This is consistent with the decision not to proceed with an adult safeguarding referral in the context of recent incidents and indicates that the primary risk category is Person Supported Experience rather than Harm to Person. A risk rating of 10, reflecting unsatisfactory person supported experience which is readily resolvable was agreed by PIC, Area manager, Head of Services, Designated Officer and Head of Quality Enhancement and Training.
• Each incident will continue to be reviewed individually and an adult safeguarding referral completed only if clear signs and indicators of abuse are indicated as per Appendix 1 of the BOCSI National Policy for Safeguarding of Vulnerable Adults at Risk of Abuse. The risk will be monitored quarterly or more frequently if required and escalated if appropriate to the escalated risk clinic for review.
• The vocalizing behavior of the resident is occurring in the context of a changing physical presentation and mental health concerns which are episodic in nature. This is subject to ongoing intervention support and review by the clinical team including Psychiatry and GP. This demonstrates a high level of oversight and awareness of the residents support needs.

• Area Manager, PIC, CNM1s met on 12th Aug 2025 to review procedures and protocol around unexplained bruising. Daily handover and night handover in place where bruising is reported and actions taken is documented.
• Incident reporting in place.
• A workshop will be delivered to staff around unexplained bruising and protocols to follow.
• PIC has reviewed two incidents of unexplained bruising which occurred in July, in line with protocols for unexplained bruising. PIC is satisfied that the incidents are not of a safeguarding concern.

• There is a shift planner in place to ensure optimal support of residents on the floor. This is incorporated into the safeguarding plan. The BOCSI-LR acknowledges the inspector's observation of a two minutes absence and wishes to assure the inspector that this would be unusual but nonetheless been flagged with staff.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The BOCSILR had identified the Person in Care account, developed by one financial institution, as the appropriate bank account to offer people supported who require support of staff employed by the BOCSILR in the management of their money.
• This account offers safeguards to both staff in accessing another person's bank account and also allows for safeguards to the person supported in protecting their money. The service recognizes that this account is inherently restrictive. The Personal Assets policy addresses this in that it sets out the nature of the support that the BOCSILR can offer to persons supported and gives individuals the choice to opt in or opt out of this support. The BOCSILR Policy on the Handling of the Personal Assets of Adults Supported by the Services includes a permission form which supports people to opt in or opt out of support from the BOCSILR in the management of their personal assets.
• The limitations to accounts with person in care features are clearly set out in the policy to support people to make an informed decision when opting in or out of support from the BOCSILR in the management of their personal assets.
• The BOCSILR is committed to exploring all alternative accounts that may facilitate less restrictive direct access to personal assets for people supported who opt in to support from the BOCSILR. Engagement with banking institutions has also been pursued to identify possible suitable banking products that would be a less restrictive alternative for residents within the service and also provide a safe arrangement for staff to support people with their finances.
• As a result of the recent ADMA legislation the Person in Care account has been withdrawn by the financial institution for new admission but existing accounts have remained open at this time. The BOCSILR are actively engaging with other institutions to find an alternative and suitable account. This institution who has withdrawn the Person in care account is recommending the use of the HSE's patient private property account which the BOCSILR deems to be further restrictive. The services have written directly to the Decision Support Service setting out our concerns regarding the current banking services available to people who require support with their finances.
• Staff to email PIC or Area Manager when money is required to be transferred to their Current account for persons supported to ensure funds are received in a timely manner.
• Keyworker and CNM1/Area Manager are expected to ensure the Person supported ledger/wallet for whom they are responsible have €200 balance when they are going off duty without exception. In the unlikely event that the key worker and CNM1/Area Manager are unavailable and the Person Supported by the Services is without money the Finance Department should be contacted with a view to providing a loan to the Person Supported on a short-term basis. Unauthorised signatories to the Person Supported

account should not access the Person Supported account with debit card.
• In exceptional cases where the key worker and CNM1/Area Manager are unavailable and a Person Supported by the Services wishes to make a purchase but he/she has insufficient cash available in his/her wallet at the time, the support staff may support him/her to make the purchase using the house visa purchasing card without advanced approval from finance subject to the following conditions: The person supported expresses a clear will and preference to purchase a specific item at this particular time and/or the person supported is at risk of losing out on good value. The person has sufficient funds to repay the Services. The support staff send an email from his/her BOCSI email address before the end of his/her shift setting out (1) the reason why it was considered necessary to make the purchase at this time, (2) details of the item purchased, (3) who it was purchased for including the debtor account nominal code, (4) the cost of same and (5) confirmation the transaction will be correctly coded on the visa return. The email should be sent to the person in charge and the Area Manager with Finance cc'd on the original email. It is mandatory to include the Finance Officer for People Supported.

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 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	31/12/2025
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/12/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	31/12/2025

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/09/2025
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	Substantially Compliant	Yellow	23/12/2025

	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.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	01/09/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	13/08/2025
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	Substantially Compliant	Yellow	30/09/2025

	behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	13/08/2025
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	01/09/2025