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:	27 January 2022
Centre ID:	OSV-0004745
Fieldwork ID:	MON-0031951

About the designated centre

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

This service is based in a purpose built premises located in a rural but populated area approximately ten minute drive from two busy towns; transport is provided. The centre can accommodate a maximum of ten residents and is designed and laid out to promote accessibility and the needs of residents with higher physical support needs. The provider aims to provide each resident with a safe, homely environment where they are to be provided with quality care and enjoy quality of life as appropriate to their individual needs and requirements. The centre is open and staffed on a full-time basis. The staff team is comprised of nursing and care assistant staff led by the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 27 January 2022	09:10hrs to 17:30hrs	Elaine McKeown	Lead

What residents told us and what inspectors observed

On the day of the inspection the inspector had the opportunity to meet all of the residents living in the designated centre. The inspector was introduced to the residents at times during the day that fitted in with their daily routine while adhering to public health guidelines and wearing personal protective equipment (PPE).

This was an unannounced inspection and residents were not expecting visitors on the day. The inspector had previously visited the designated centre in August 2020. When speaking to residents during this inspection they were reminded of this by the inspector. Some residents were able to outline how they had coped with the pandemic restrictions since then and others outlined their plans going forward. The inspector was informed that due to some changes in the assessed needs of the residents since the last inspection, all of the residents required ongoing staff support. This included three residents who required two staff to support them with some activities of daily living, (ADLs).

On arrival the inspector was introduced to three residents in the dining room who were eating their breakfast independently. They greeted the inspector with elbow taps and big smiles. There were a few questions from the residents for the inspector to answer. After a short conversation the inspector left the residents to finish their meal without further interruption and spoke with some of these residents later in the day.

The inspector met two other residents who were in the living room. One resident was observed to be sleeping in their comfortable chair that was in a reclined position and it was evident they had been supported with their personal care by staff. The inspector was informed that this resident required support with all of their ADLs. During the day the inspector observed staff supporting the resident to eat and drink in an un-rushed manner in a quiet environment. Staff spoken to were familiar with the dietary needs of the resident and also outlined how the resident enjoyed massage activities and foot spas. During the afternoon other residents were observed to be in the living room participating in a group activity and a staff member was sitting next to this resident to provide support and reassurance through conversation and informing the resident what was happening. The group had planned to have a sing song but due to technical difficulties with the music this had to be changed to different table top activities.

Another resident spoke to the inspector about their regular visits from family representatives and detailed how they spoke with siblings regularly during the week on the phone. The resident smiled as they spoke of a favourite singer and they were observed to be drinking out of a cup with this person's image printed on it as they conversed with the inspector. They informed the inspector they were happy living in the designated centre and enjoyed the company of their peers. They felt safe and identified staff they would speak to if they had any concerns. Staff were observed to be very familiar with the resident's preferences and offered support during the

afternoon for the resident to contact a named relative. The resident also spoke about their new wheelchair that they were sitting in while talking to the inspector. They outlined how they were happy to be able to mobilise independently around the designated centre. However, they mentioned that they were a little sore on one side and that the occupational therapist, (OT) had visited them to see if the issue could be fixed. The person in charge later outlined that the issue was related to an ongoing medical condition affecting the resident's spinal posture. While a solution was been looked into, the OT had advised that additional postural support could reduce or eliminate the resident's ability to self-propel themselves. The resident was providing staff and the OT with updates on how comfortable they were feeling in their new chair and this was under regular review.

One resident met with the inspector before they left the designated centre to attend their day service. They showed the inspector a ring that they had on their finger explaining that they had gotten it as a present. They were looking forward to a hair appointment that was booked for the following week and spoke about being able to go back to partaking in bowling activities and having meals out now that the restrictions were being eased. They spoke about their personal health and how they needed to go to hospital on a number of occasions since the last inspection. They were happy to be able to go to their day service five days a week with a dedicated staff supporting them. The inspector was aware the provider had facilitated this resident to return to a bespoke service since January 2021 to support their assessed needs. The resident explained how they enjoyed an individual service and had the use of dedicated space complete with a fire and television. They spoke of the activities they enjoyed during their day which included beauty treatments, getting their nails done and making posters along with other art work. Staff explained to the inspector that the resident enjoyed the peace and quiet in their day service. The inspector was aware that this resident had repeatedly requested to be supported in an alternative setting with an individual residential service. The resident gave the inspector an update that they were going to be able to move into a nearby building once the required works were done. They told the inspector that they were happy with this development and were looking forward to this happening during 2022.

Staff also informed the inspector how one resident enjoyed spins in the community since the pandemic restrictions were imposed. Prior to the pandemic the resident only left the designated centre with family representatives as the resident did not like to travel on the transport vehicle. However, when family representatives were unable to visit, staff were able to use a smaller vehicle and supported the resident to go out with staff. This had a positive impact for the resident. The inspector met this resident a number of times during the day as they walked around the designated centre with their walking aid and non-slip footwear as per their choice. The resident did not like to wear shoes or other types of footwear when inside the designated centre. Staff were observed by the inspector to understand what assistance the resident required when the resident used gestures to indicate their need on one occasion during the day. Later in the day the resident made their way to their preferred chair in the living room where they enjoyed a hot drink. While this resident did not appear to engage with their peers very much they did respond with smiles to staff during their interactions. They also chose to spend some time lying

on their bed during the day.

On the day of the inspection a transport vehicle which is usually available to the residents in the designated centre was undergoing scheduled maintenance which directly impacted on some residents being able to engage in social activities or to go out out for spins in the community. Three residents were supported to attend their regular day service in another transport vehicle as per usual. The remaining seven residents were supported to engage in some activities during the day. These included one resident going out to a nearby shop with a staff member to purchase items as per their request. Other residents completed table top and craft activities. However, the inspector observed the staff throughout the day providing ongoing support to residents with ADLs. In some instances, two staff were required to support individual residents which left one staff at times supporting the remaining six residents. This directly impacted on the amount of time residents were being supported to engage in meaningful activities in the designated centre.

The inspector observed during the inspection the atmosphere was relaxed and the noise levels were reduced when there was reduced numbers of residents in the house. It was evident during the inspection that all staff were familiar to the residents and supported the residents in a professional and respectful manner. The inspector observed all interactions between the residents and staff were positive in nature.This was also observed by the inspector as other staff came on duty at different times during the day. The inspector noted residents interacted with ease and engaged with the staff in different locations in the designated centre throughout the inspection.

Some of the residents outlined how they had been supported in the designated centre during a period when there had been an outbreak of COVID-19 in September 2021. They spoke of how the staff team looked after the residents in different areas in the designated centre. Four residents did not contract the virus and were supported to remain well by a dedicated team. Six residents who did contract the virus were supported in a zoned area in the designated centre with another dedicated staff team. Each area had separate entrances and protocols were in place to ensure no cross over of staff or residents into the zoned areas. While some staff also contracted the virus the provider ensured the skill mix of staff was maintained with nursing staff on duty on every shift. Staff were redeployed from other areas supporting the core staff team. All residents and staff recovered from the illness. Safe practices were also observed throughout the inspection in relation to infection prevention and control. Hand sanitising dispensers were located in a number of areas, all of which had adequate supply of sanitising fluid when checked by the inspector and staff were observed to use these regularly throughout the inspection. Staff were observed to clean the thermometer after each use and temperature checks were carried out as per the provider's policy. However, the provider had not ensured a review of the contingency plan had been completed since March 2020 and no review of service provision after the outbreak had been completed. This will be further discussed in the quality and safety section of the report.

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

Based on the overall findings of this inspection, while progress had been made by the provider to support an individual resident in relation to their expressed wish to move into a single occupancy dwelling, the provider had not ensured the service provided to a number of other residents was consistently safe and appropriate to their assessed needs. The provider had recently completed another review of safeguarding within this designated centre and submitted retrospective notifications to the Health Information and Quality Authority, (HIQA). This had been an action from the previous inspection but only two retrospective notifications were submitted at that time. The most recent review by the provider of adverse interactions between residents resulted in more retrospective notifications being submitted in the weeks prior to this inspection. Some of these adverse incidents had occurred prior to the last inspection. In addition, the inspector did not see evidence that all adverse incidents were being managed as per the provider's policy.

The inspector reviewed the complaints log and noted that one resident had made three complaints regarding the actions of a peer who was upsetting them. While the person in charge had reviewed each incident individually, the inspector noted that on each occasion the same peer was causing upset to the resident by their actions. Staff documented that they supported the resident at the time, each complaint was then closed. The provider's complaints log directs staff to complete a particular section if the complainant is satisfied. However, the inspector did not see evidence the complainant was satisfied with the outcome on all of these occasions. The trend of similar adverse interactions between these two peers had not been identified by staff prior to this inspection.

Also, the inspector noted that staff were not consistently reporting similar adverse events. If an adverse event involved a particular resident it was reported as an incident. These would include shouting at peers. However, if another resident reported a similar incident it was managed as a complaint. Staff spoken too outlined their rationale for this process to the inspector. This was based on their knowledge of the individuals involved. However, each resident who reported the incidents stated they were upset by the interaction and required staff support to ensure they were kept safe in their home.

In addition, while there were three open complaints at the time of the inspection, the progress and actions taken by the provider was not always documented. The inspector was informed of what the provider had done to seek a solution and written correspondence was sent to the complainants involved in two of the complaints. However, some of these documents were not available for review during the

inspection or had not been noted as being completed in the complaints log. These complaints had been escalated as per the provider's policy and actions were in progress to support these complaints to be resolved at the time of the inspection.

The person in charge worked full time and had remit over this designated centre only. They had taken up the position in September 2020 and were aware of their role and responsibilities. They demonstrated a very good knowledge of the residents and their support needs. They were very familiar with the residents and had worked in the designated centre prior to taking up the role of person in charge. Although their role was supernumerary, due to staffing issues they also provided direct support to residents at times during the pandemic. Most recently during an outbreak of COVID-19. This requirement had impacted on their ability to complete all of their responsibilities including supervision of staff as per the provider's policy in 2021. However, regular monthly staff meetings had been maintained using video conferencing. The person in charge outlined how they anticipated the recent addition of new nursing staff to the team as being a benefit to assisting them in their ability to delegate some duties such as auditing and review of personal plans for residents.

The provider had successfully recruited additional staff which included nursing and care assistants. A total of four new staff members had joined the team in the few months prior to this inspection. The inspector met with some of these staff during the inspection. Their positive interactions with the residents and other staff members was evident. They were aware of safeguarding protocols in place and the assessed needs of the residents they were supporting. The inspector was informed that there were no staff vacancies at the time of this inspection. However, while the number of staff on duty were as outlined in the statement of purpose, staff duties throughout the inspection centred on supporting residents with their ADLs. There was limited time for seven residents on the day to engage in meaningful activities as per their choice.

The provider had ensured an annual review and provider led six monthly audits were completed in the designated centre. The most recent audit completed in November 2021 identified difficulties for staff to support residents remaining in the designated to engage in activities due to the increased supports required by residents. This remained an issue at the time of this inspection. In addition, the provider outlined in the annual review completed in January 2021 that retrospective notifications had been submitted to HIQA, However, as previously mentioned additional adverse events that occurred in 2018, 2019 and 2020 were subsequently notified in December 2021 and January 2022 after a further review. A total of nine retrospective notifications were submitted during this period.

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed to work full time and they held the necessary skills and qualifications to carry out their

role. In addition to the responsibilities of this role, the person in charge provided frontline support to the residents and the staff team during a recent outbreak of COVID-19 in the designated centre.

Judgment: Compliant

Regulation 15: Staffing

There was an actual and planned roster in place. The provider had ensured the skill mix and staffing vacancies had been reviewed since the last inspection. However, due to the evident changes to the assessed needs of some residents the number of staff available to support residents to engage in meaningful activities required further review. This will be actioned under regulation 13: general welfare and development.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had a training schedule in place with training planned and booked for staff in 2022. However, at the time of the inspection not all staff had completed refresher training in fire safety and managing behaviours that challenge. In addition, the review of compliance with this regulation was difficult to fully assess as there was a core group of 19 staff with an additional eight regular relief staff employed in the designated centre. While the individual training records of each staff member were presented for review during the inspection it was difficult to extract all the required information regarding the current status of all staff in relation to up-to-date training in mandatory courses. In addition, staff supervision had not been held at the frequency outlined in the provider's policy, this will be actioned under regulation 23: Governance and management.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had governance, leadership and management arrangements in place in the designated centre. However, effective arrangements were not in place to support, develop and performance manage all members of the staff team. In addition, due to the changing needs and increased supports required by the residents evident during the inspection, the service provided required further review

to ensure it was appropriate to all residents' needs, consistent and effectively monitored.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which was subject to regular review and reflected the services provided in the designated centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had completed a retrospective review of safeguarding incidents in this designated centre in the months prior to this inspection which resulted in a number of notifications being submitted; these included incidents that had occurred prior to the last inspection in August 2020. The provider had not ensured all retrospective notifications following the last inspection in August 2020 had been submitted as requested at that time. In addition, following a review of documentation by the inspector, assurance was not provided of how a number of adverse incidents reported by one resident were managed by the provider.

Judgment: Not compliant

Regulation 34: Complaints procedure

At the time of the inspection there were three open complaints. While information was provided to the inspector regarding the resolution of these complaints, it was not always documented the actions taken by the provider to inform the complainant of the outcome of progress of the resolution being sought. In addition, following a review of the complaints log, the inspector noted not all incidents of a safeguarding nature were responded to in a consistent manner and in line with the provider's policies and procedures. For example three incidents reported to staff by a resident had been documented and managed as a complaint made by one resident regarding the impact of another peer's actions on them in recent months which resulted in the resident being upset.

Judgment: Substantially compliant

Quality and safety

The inspector observed residents being supported by a familiar staff team with the provider actively working towards responding to the expressed wishes of residents. However, there were concerns around the inconsistency in the application of safeguarding procedures to all residents, this was also a finding in the previous inspection of September 2020. Not all residents personal plans had been subject to regular review and healthcare issues for some residents remained outstanding with the date for review by healthcare professionals elapsed. In addition, not all residents were consistently supported to engage in meaningful activities daily and issues relating to maintenance of the premises and furniture were evident.

The inspector completed a walk around of the designated centre and observed areas where maintenance was required. Some areas of paintwork had multiple scuff marks and furniture surfaces were observed to be worn away. These issues included damage to floor surfaces in multiple locations such as bedrooms and the hall ways. There was mould evident on the walls in the utility room, where paint was also peeling off the walls. In addition, there was visible damage to the surface of a table covering in the sitting room with evidence of wear and tear. This was also the issue with some chairs that were being used in multiple areas around the designated centre. The damaged surfaces as outlined also impacted the ability of staff to ensure effective cleaning of surfaces was being carried out.

Staff practices throughout the inspection evidenced good infection prevention and control practices which included adhering to the provider's policy on temperature checks three times for staff while working a long shift. In addition, staff had ensured cleaning of frequently touched points and equipment were consistently completed with the duties shared among the staff team on duty on each shift. However, at the time of this inspection the contingency plan specific to this designated centre had not been reviewed since March 2020. The provider had completed a service wide review of their contingency plan in November 2021. In addition, no review of the provision of services post an outbreak of COVID-19 was completed in the designated centre. While the inspector was aware of effective measures that had been put in place during the outbreak which successfully prevented four residents from contracting the virus, the lack of a review was a missed opportunity for learning and ensuring effective management if a similar situation occurred in the future.

It was observed by the inspector that the designated centre was provided with all expected fire safety systems including fire extinguishers, a fire alarm and emergency lighting. Such systems were being serviced at regular intervals by external contractors to ensure that they were in proper working order. Provision had also been made for fire containment in the house in order to prevent the spread of fire and smoke while also providing a protected evacuation route if needed.

However, no minimal staffing fire drill had taken place since 13 August 2020. That drill included only nine residents and was completed before the last inspection in

September 2020. No minimal fire drill to support 10 residents to safely evacuate had been completed since the last inspection. The format of the fire drills used compartmental evacuation and staff spoken to on the day of the inspection outlined how this was completed with different senarios. Drills were documented as being completed in less than two minutes 30 seconds. Some fire drills outlined issues that were encountered which included moving six residents in wheelchairs and some residents refusing to participate. On review of residents' personal emergency evacuation drills, (PEEPs), the inspector noted emergency equipment such as evacuation sheets being required to evacuate residents from their beds. However, these were not present when the beds were checked by the inspector. In addition, staff were not consistently completing the weekly fires safety checks as per the provider's policy. For example, no checks were documented as being completed between 3 December 2021 and 9 January 2022

There were nine active safeguarding plans at the time of the inspection. However, from records reviewed there had been a number of incidents involving negative interactions between residents. The nature of such incidents were safeguarding in nature and some of these had been reported and responded to in a manner that was consistent with the provider's safeguarding policies and procedures. In response to such matters safeguarding plans were put in place with actions taken to reduce the possibility of similar incidents happening again. For example, one resident had recommenced day services away from the house which limited the time that residents would be spending together.

Despite this, not all incidents of a safeguarding nature were being reported and responded to in a manner that was consistent with the provider's safeguarding policies and procedures. In particular, the inspector read reports where the actions of one resident were directed towards another resident. For example, there were reports of one resident shouting at another resident. These were queried on the day of inspection and it was indicated to the inspector that such matters were reviewed and considered not to be abusive. However, based on the reports reviewed, there was clear indications of a negative psychological impact with some reports indicating that an impacted resident was either anxious, upset or left a room following such adverse events.

The provider's own safeguarding policy indicated that psychological abuse included, amongst others, threats of harm and verbal abuse, with an example of this being shouting while anxiousness and tearfulness were listed as indicators of psychological abuse. The provider's safeguarding policy also provided for a zero tolerance approach to abuse which emphasised that any abuse should not be normalised or ignored even if the impact and intent appears not to be significant. This policy extended to concerns against residents and indicated that a preliminary screening or investigation should be carried out for all allegations of abuse. Despite this, screenings for some of the adverse events read by the inspector had not been carried out. The staff team had dealt with these situations as complaints. This was inconsistent with the provider's own policies and procedures in this area.

Residents who were able to engage in solitary activities were supported to do so

during the inspection. For example, one resident enjoyed completing an activity with beads. However, two staff were observed to try to engage five residents with different assessed needs in a group activity during the afternoon. Some of the residents were not able to participate as much as others. In addition, two other residents preferred to not join the group and were observed to spend time sitting in another communal area. One of these residents engaged in a conversation with the inspector during this time. The resident spoke about what they liked to do and how they had enjoyed going shopping the previous week with staff to buy new shoes. They spoke of how they liked to go out for spins in the community and meet other people. As previously mentioned the transport vehicle was having maintenance work done so there was a lack of transport available on the day of the inspection. The inspector noted there was no staff available to sit with this resident and support them to engage in an activity of their choice during this period of time. The resident was observed to sit with staff in the office on a number of occasions during the day. The inspector was informed that the resident liked to sit and chat with staff as they liked to have the company of others. Staff explained that while they were aware residents sometimes had different preferences, it was difficult to ensure all residents could engage in meaningful individual activities on a regular basis.

The person in charge outlined how not all residents personal plans had been subject to regular review in the last 12 months. However, with the recent addition of new staff to the core team, there were plans for a review of keyworkers for residents with a link staff to support the review of plans. In addition, the review and progression of goals would also be a focus. The inspector was informed that some goals for residents had been achieved such as travelling on a train or meeting a friend for dinner. However, the progression of these goals and others had not been documented.

Some residents were under the care of consultant services for ongoing healthcare issues, However, following a review of three healthcare plans the inspector noted one resident had not had a cardiology review documented since March 2020. The resident was due to been seen again in an outpatient clinic in 12 months. The inspector was informed that a consultation had taken place over the phone due to the pandemic restrictions, but this was not documented and at the time of this inspection no follow up appointment for the resident was scheduled. The same resident had also been reviewed by an optician in August 2021 who recommended a referral to consultant services due to changes detected at that time. No appointment had yet been secured. Another resident had been seen in April 2021 regarding management of a urology issue. It was documented that the specialist team would be in contact regarding the next appointment, however a follow up appointment had yet to be scheduled.

Regulation 11: Visits

The provider had ensured that residents were supported to maintain regular contact with family representatives and friends. Staff also facilitated visits to residents'

family homes while adhering to public health guidelines and as per the residents' expressed wishes.

Judgment: Compliant

Regulation 13: General welfare and development

The provider supported some residents to attend day services as per their assessed needs. However, while a number of residents were supported with activities in the designated centre, the demands on the staff team to meets the ADLs for all residents impacted on the ability for residents to engage in meaningful activities as per their wishes during the day.

Judgment: Substantially compliant

Regulation 17: Premises

The provider had not ensured some areas of the designated centre and furnishings had been consistently maintained in a good state of repair.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had ensured there were systems in place for the identification and management of risks in the designated centre. However, not all risks had been the subject of regular review and reflected the up-to-date controls in place. For example, the risk relating to re-engaging in visiting was documented to be reviewed in August 2021 but this had not been completed.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had ensured that there were supplies of hand gel and PPE available. Staff members on duty were seen to wear face masks throughout the inspection. Signage around hand hygiene, PPE and COVID-19 were on display in the house while provision had been made for ventilation. Visitors' logs were present for anyone

arriving at and leaving the house. However, no site specific contingency plan review had been completed since March 2020 and no review of service provision post an outbreak of COVID-19 had been completed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had ensured that effective fire safety management systems were in place in the designated centre, including fire alarms and emergency lighting. However, no minimal staffing fire drill had been carried out with all residents. In addition, residents PEEPs required further review as details included in some plans were not reflective of emergency equipment available for staff to use in the event of an night-time evacuation being required from the designated centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plans for residents had not been subject to regular review and progression of goals had not been consistently documented, however the provider has a plan in place to address this.

Judgment: Substantially compliant

Regulation 6: Health care

While each resident did have a healthcare plan not all residents ongoing healthcare needs had been subject to follow up review as documented in their care plans. In addition, not all consultations with allied healthcare professionals had been documented.

Judgment: Substantially compliant

Regulation 8: Protection

A number of adverse events had occurred in this centre since the previous inspection which had negatively impacted residents living there. While the provider

was making ongoing efforts to prevent these from happening, some of these incidents had been reported, screened and investigated but others had not.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Lios Mor OSV-0004745

Inspection ID: MON-0031951

Date of inspection: 27/01/2022

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • There is now a training record on one page in training folder with all staff names and the current record of their training status on all mandatory training. This will be updated by PIC as staff update their training as required. • Fire training has been completed by the two staff who required training as planned on the 9th of February 2022. All staff are now up to date with fire training. • Staff are scheduled to attend Mapa as per training calendar. Staff who are due to be trained in Mapa will have their training complete by the 30th of June 2022.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • PIC and the two new C.N.M.1's will share out staff support and supervision duties to be carried out every 3 months as per policy. • Support and supervision will be completed with all staff by 30th March 2022 and will continue every 3 months thereafter. • There is a risk assessment in place reflecting the impact of the staffing requirement to support resident with high activities of daily living (ADL) support needs which is having an impact on the daily meaningful activities of residents in Liosmor who are not attending a day service. This will be escalated to the next red risk clinic on the 25th of March 2022. • Additional control required in the risk is for business case to be prepared for an activation staff to be funded for residents in Liosmor. The business case will be completed by 30th April 2022.	
Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Staff are all up to date on safeguarding training.
• Discussion was held at staff meeting on the 23/2/2022 outlining the different types of abuse and the procedure for the reporting of safeguarding issues.
• Staff to discuss with residents if they are upset or impacted by the behavior of a peer (where not witnessed by staff) to get an insight of what was said or done and record appropriately.
• Staff to discuss with PIC/CNM1 or Designated officer if needing further clarification.
• All staff must fill up a CP1 Form and follow safeguarding policy if incident is considered as abuse.
• PIC to notify HIQA within three days of incident.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Documentation in place outlining the progress of actions taken by provider in relation to the complaint, which have been communicated to the resident that made the complaint.
• Meeting with the designated officer, Area Manager, Head of Community Services and the Person in Charge on the 2/2/22 to review the 3 complaints by one resident the past 12 months noted by inspector. The team were satisfied that these complaints did not meet the definition of abuse.
• M.D.T held on 7/2/22 to review the person that made the complaint.
• Guidance document prepared by psychologist for staff regarding the support to be provided to the person supported to encourage positive engagement with her peers.
• Further MDT to review monitoring form to be held by the 30th of March 2022.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• There is Risk assessment now in place reflecting the impact of the staffing requirement to support resident with high ADL needs in Liosmor which is having an impact on the daily meaningful activities of other residents in Liosmor who do not attend a day service. This risk will be escalated to the next red risk clinic on the 25th of March 2022 .
• Business case to be completed for funding of an activation staff for Liosmor from Monday to Friday by April 30th 2022.
• Plans to be made at house meetings to ensure each resident has an activity of their choice accommodated each week.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Chairs will be covered in wipe clean/fire retardant fabric by Interior designer completed by the 30th March 2022.
• Painting to be completed by the 31st December 2022

• Floors will be repaired by the 31st of December 2022 • Deep clean will be completed on the 8th of March 2022

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • All risks are currently reviewed. • The risk register will be reviewed in a timely manner as per risk management policy	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • Contingency plan now in place for Liosmor. Plan to complete review of service provision post outbreak of Covid 19 to be completed by 30th March 22. • Hiqa Self-assessment tool complete and will be reviewed every 12 weeks • Infection control cleaning carried out twice by day and night • Temperature monitoring of residents twice a day and three times for staff • PIC carries out monthly check list for infection control measures in Liosmor and actions taken as required. • Staff continue to wear FPP2 masks and follow public health guidance.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Minimal staffing fire drill completed on the 31/1/22, all residents evacuated within 2 minutes with 3 staff and 10 Persons supported. • All peeps reviewed on the 31/1/22 and rewritten reflecting emergency equipment available in the event of night time evacuation of Liosmor	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • PIC met with keyworkers outlining personal plans and the PCP's in need of review. • Seven residents are in the information gathering stage of new P.C.P. • Information gathering will be completed by Keyworkers by the 30th of March 2022. • Planning meetings to be then scheduled and completed by April 30th 2022. • Three PCP 'S are in date. • Key workers in the process of updating personal information plan- To be completed by April 30th 2022	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care:	

• Health care plans of all residents currently being reviewed by two C.N.M.1's and PIC to be completed by March 30th 2022.
• Follow up appointment in place with cardiologist on March 13th 2022 for resident identified by inspector during the inspection.
• Confirmation of G.P referral made on the 7/2/2022 for one resident for a urology consultation
• All healthcare appointments will be completed on appointment forms with the healthcare plans being updated as required.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Staff meeting was held on the 23/2/22 outlining the different types of abuse and what the indicators of abuse are.
• All staff made aware of acting on any form of abuse and following B.O.C policy in completing CP1 form and reporting same to D.O for preliminary screening.
• Safeguarding plans in place for residents regarding ongoing concerns of another resident.
• Alternative accommodation has been funded by H.S.E for this resident with assessments currently taking place with organization to accommodate the residents needs.
• Risk assessment in place since the 29/11/21 for one resident that maybe impacted by the challenging Behaviors of other person.
• Meeting with the designated officer, Area Manager, Head of Community Services and the Person in Charge on the 2/2/22 to review the 3 complaints by one resident in the past 12 month noted by the Inspector. These were reviewed to see if indicators/signs of abuse were present. The team were satisfied that these were not present. All agreed that that this was a complaint and not a CP1.
• It was noted that complaints were not documented well at the time. Report writing guidelines to be reviewed at next staff meeting.
• Person of concern was happy with the outcome. Going forward staff should verify same at the time the issue is raised.
• Guidance issued at PIC meeting on 23rd February that rationale for a decision re the treatment of an incident be set out clearly on the AIRS form.
• M.D.T held on 7/2/22 to review the person that made the complaint.
• Guidance document prepared by psychologist for staff in order to support them in supporting positive engagement by one resident with her peers.
• Further MDT to review monitoring form to be held by the 30th of March 2022.

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 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.	Substantially Compliant	Yellow	31/08/2022
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	30/06/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	31/12/2022

	kept in a good state of repair externally and internally.			
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.	Substantially Compliant	Yellow	30/08/2022
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/03/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for	Substantially Compliant	Yellow	30/04/2022

	responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/03/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/01/2022
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,	Not Compliant	Orange	28/02/2022

	suspected or confirmed, of abuse of any resident.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	30/03/2022
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	30/04/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and	Substantially Compliant	Yellow	30/04/2022

	new developments.			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	30/03/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2022
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.	Substantially Compliant	Yellow	30/03/2022