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:	10 May 2023
Centre ID:	OSV-0004745
Fieldwork ID:	MON-0039924

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 one storey building located in a rural area but within short driving distances to some towns. The centre provides full-time residential support for up to 10 residents of both genders over the age of 18 with intellectual disabilities. Ten resident individual bedrooms are provided with four sets of Jack and Jill bathrooms for eight of these bedrooms. Other facilities available for residents include a living room, day-dining room, a kitchen, bathrooms and a staff office. Support to the 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:	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
Wednesday 10 May 2023	09:25hrs to 19:00hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Two residents spoken with talked positively about the centre. Most residents spent part of the day away from the centre attending day services or on an outing. While large parts of the centre were seen to be well presented, storage was an issue.

Ten residents were living in this centre all of whom were present on the day of inspection with nine of the residents met by the inspector. While some spoke with the inspector, most did not engage verbally with him. On arrival at the centre some residents were in the centre's communal area having breakfast while others were in their bedrooms being supported by staff on duty in getting up and receiving personal care. During this initial period of the inspection the centre was quiet but the inspector did speak to one of the residents. This resident showed the inspector some watches that they had on and indicated that they liked the centre and going home to their family. The inspector was also informed by the resident that they were going to day services in a nearby town that day.

As the inspection progressed a total of six residents left the centre to attend day services operated by the same provider. Two of the remaining four residents also left with some staff for much of the afternoon to go to a garden centre and café while the other two residents remained in the centre for the day. One of these residents was seen at one point doing some table top activities and smiled when approached by the inspector but otherwise did not engage with him. The other resident did occasionally verbally engage with the inspector and staff remaining in the centre but was observed to spend some time time sitting in a staff office which appeared to be the choice of the resident.

With the centre being less populated for much of the inspection, the premises provided for residents to live in was reviewed during this time. In general, the communal areas of the centre were seen to be nicely presented, well-maintained and clean with the inspector informed that new flooring and worktops had been recently installed in some of these areas. Each resident had their own individual bedroom also. Some of these were seen by the inspector which were observed to be well furnished and personalised to residents with storage facilities such as wardrobes and chests of drawers provided for. Despite this in some other areas of the centre, some issues with storage were noted.

For example, in one of the centre's sluice rooms, a number of boxes of sanitary products were stored with some of the sanitary products seen stored in the sluice room's sink. The inspector was later informed that this sink was no longer in use. In addition, it was also noted that a second sluice room was noticeably cluttered and had various containers, boxes of more sanitary products and cleaning supplies present. Some laundry was present in this room hanging from a clothes horse and it was observed that such laundry was in proximity to some mop buckets that were seen used for cleaning during the inspection.

It was acknowledged by management of the centre that there were some issues with storage in the centre. The inspector was informed that this was contributed to by works being carried out on a building adjacent to the centre that was previously used for storage. Such works were due to be completed in the coming months and it was also outlined how the centre would be getting an external shed to help with storage. Despite this, the observed storage issues during this inspection did not promote effective infection prevention and control practices with the inspector also noting some areas in the centre's laundry that needed further cleaning.

Aside from this it was seen though that the premises provided for this centre was equipped with fire safety systems such as a fire alarm, emergency lighting and fire extinguishers. Records provided indicated that these were being serviced by external contractors to ensure that they were in proper working order. Fire containment measures were also present and it was noted that the centre was divided up into different zones to support a phased evacuation in the event of a fire. In addition, there were multiple fire exits around the centre with these seen to be unobstructed on the day of inspection. Exit doors were present in eight of the ten resident bedrooms.

Later in the afternoon the residents who had left the centre earlier in the day began to return to the centre with residents supported into the centre's communal area in advance of a meal being served. Facilities were provided within the centre for food to be stored such as in the centre's kitchen and pantry. Facilities were also in place for food to be prepared and at this time two chickens were being roasted in an oven which provided a nice smell. The inspector was informed by a staff member that all meals were prepared in the centre and that residents were asked about their choices of meals during resident meetings.

The inspector briefly spoke with the resident he had talked with earlier in the day who indicated that they had a good time at day services. Another resident told the inspector that they too had gone to day services and liked this. The resident also told the inspector that they liked living in this centre and when asked what they liked about living there the resident indicated that they enjoyed sleeping in the centre and reading books. The resident appeared happy and smiled during this conversation. When asked by the inspector, the resident also indicated that they felt safe living the centre, liked the other residents living the centre and was happy with the staff. As the inspection neared its conclusion the inspector did observe some pleasant interactions between residents and staff.

For example, a member of the centre's management was overheard explaining to residents who the inspector was using a 'Nice to meet you' document provided while a resident was supported by one staff member while the resident used a peg board. There was more noise heard at this time compared to the morning of the inspection although much of this was coming from one resident who was asking a number of questions with a staff member present responding to these. Shortly after such observations one resident received a visit from a relative. As the inspector was leaving the centre the majority of residents were in the centre's centre communal areas with staff who were completing some paperwork.

In summary, residents had their own individual bedrooms in the centre with large parts of this centre seen to be well presented. Despite this storage was issue which did pose some challenges regarding infection prevention and control. Two residents were in the centre for all of the inspection but the other eight residents did leave the centre to go on an outing with staff or to attend day services. Two residents spoken with indicated that they liked 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

Based on the findings of this inspection, concerns were identified regarding the concerns raised by staff of this centre and the submission of required notifications to the Chief Inspector of Social Services.

Previous regulatory engagement concerning this centre during 2021 and the previous Heath Information and Quality Authority (HIQA) inspection in January 2022 highlighted some concerns around one resident's wish to move into a single occupancy dwelling and the impact that this resident was having on their peers. Since that inspection confirmation was received from the provider that this resident had transitioned to another service provider in April 2022. With a view to supporting this resident to live in a single occupancy dwelling, the provider had commenced premises works in a building adjacent to this centre. Upon their completion it was the intention of the provider to add this building to this designated centre with the relevant resident to be offered the choice as to whether they would come and live in this refurbished building. These works were ongoing at the time of the current inspection and it was uncertain if the resident would opt to return.

Aside from this the Chief Inspector also received some notifications which raised concerns around safeguarding and practices in the centres. Some of these matters had been investigated while a further investigation was ongoing. However, given the nature of the notifications received the current inspection was conducted with a primary focus on safeguarding. Staff spoken with during this inspection demonstrated a good knowledge of who to raise safeguarding concerns and Information was on display in the centre highlighting who the designated officer (person who reviews safeguarding concerns) was. Records provided indicated that all staff working in the centre had undergone relevant safeguarding training. Notes of staff team meetings read by the inspector also indicated that safeguarding matters were regularly discussed while formal staff supervisions were also taking place. Supervision records reviewed also made regular reference to safeguarding issues.

Despite this, when reviewing records relating to the safeguarding notifications

received and taking into account discussion with management on the day of inspection along with post inspection information received, there was evidence that multiple staff members had not raised some concerns in a timely manner. Given the nature of these concerns information provided indicated that there was limited supervision of staff practices by management of the centre at certain times. Following the inspection the provider acknowledged a gap of supervision of some staff. . In addition, this inspection found that required notifications to the Chief Inspector around safeguarding matters, misconduct allegations and some instances of residents having minor injuries in this centre had not been notified as required. This was despite the two previous inspections of this centre in January 2022 and September 2020 finding Regulation 31 Notification of incidents as non-compliant. This did not provide assurances that the provider had sufficient oversight of this centre nor was learning from previous inspections particularly as issues around safeguarding and the notification of required incidents or allegations had been the subject of regulatory engagement between HIQA and the provider during 2021 with some similar issues also highlighted during some 2022 inspections of the provider's other centres in the Limerick area.

Matters related to some safeguarding incidents in this centre will be discussed elsewhere in this report. Aside from this it was noted that some staffing arrangements had improved since the previous inspection with the provision of nursing staff working in the centre having increased. This was important given the assessed needs of residents living in this centre. Planned and actual staff rosters were being maintained but when reviewing these, and from talking with staff members, it was highlighted that there could occasions where staffing levels at night could be lower. It was indicated though that this happened rarely. In addition, the January 2022 inspection had highlighted that the number of staff available to support residents to engage in meaningful activities required further improvement. A recently reviewed risk assessment related to this as read by the inspector indicated that extra staff for activities were required and the provider had requested funding for such staff. While this funding was outstanding at the time of this inspection it was acknowledged that since the January 2022 inspection, the number of residents attending day services away from the centre during weekdays had increased. As a result the risk around residents engaging in meaningful activities had reduced.

Regulation 15: Staffing

From talking with staff members and reviewing rosters there had been occasions where staffing levels at night could be lower. A recently reviewed risk assessment relating to residents engaging in meaningful activities indicated that extra staff for activities were required.

Judgment: Substantially compliant

Regulation 16: Training and staff development

While formal staff supervisions were taking place, given the nature of the concerns that had been raised in the centre, information provided indicated that there limited supervision of staff practices by management of the centre at certain times

Judgment: Not compliant

Regulation 23: Governance and management

When reviewing records relating to the safeguarding notifications received and taking into account discussion with management on the day of inspection along with post inspection information received, there was evidence that multiple staff members had not raised some concerns in a timely manner. This did not provide assurance that all staff were adequately supported, developed and performance managed around their professional responsibilities for the quality and safety of services delivered. This inspection found recurrent actions in some regulations. This did not provide assurances that the provider had sufficient oversight of this centre and that learning from previous inspections and regulatory engagement in this and other designated centres in the Limerick area.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

This regulation was not reviewed in full during this inspection but it was noted that one resident's contract for the provision of services had not been updated to reflect their admission to this designated centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed during this inspection and while it contained most of the required information and had been updated to reflect a recent change in person in charge, details of the total staffing compliment assigned to this centre required reviewed while all of the information in the centre's current registration certificate was not contained within the statement of purpose.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Instances of residents suffering minor injuries had not been notified on a quarterly basis as required. Allegations and incidents of a safeguarding nature had not been notified within three working days nor had some staff misconduct issues.

Judgment: Not compliant

Quality and safety

Inconsistencies in the safeguarding procedures followed in this centre were identified. Improvement was also needed around fire evacuation procedures and fire drills.

As highlighted earlier in this report, some matters around safeguarding and practices in the centres had either been investigated or were the subject of ongoing investigation at the time of this inspection. While the process of any going investigation was not reviewed by the inspector during the course of this inspection, he did review details around how and when concerns were raised along with other matters which had the potential to negatively impact residents. These included instances of when some residents could be impacted by other residents they were living with. When speaking with some staff members during this inspection, it was indicated to the inspector that there were no safeguarding concerns in the centre. It was mentioned by such staff that one resident could be vocal but that this would not impact other residents. However, when the inspector reviewed incident records in the centre, there were some instances where the presentation of a resident, including their vocalisations, had negatively impacted some of their peers.

For example, in one incident report a resident was described as being verbally aggressive when on a bus and attempted to kick two of their peers which resulted in the residents impacted putting their hands over their ear and lowering their heads. On another occasion the same resident kicked the wheelchair of another resident causing the latter to become upset. While it was acknowledge that the provider had taken measures to reduce the potential for such interactions, the incidents as described did appear to have a negative psychological impact for impacted residents. Given the nature of these incidents the inspector queried if such incidents had been considered as being safeguarding matters. It was indicated to the inspector that they had not as the resident's behaviour was not directed towards other residents but was directed at staff. However, this approach to these incidents appeared contrary to previous approaches taken by this provider in this centre.

During the 2021, the provider, at the request of the Chief Inspector, undertook a review of incidents occurring in its designated centres in the Limerick area. As part of this some retrospective safeguarding notifications were submitted to the Chief Inspector in December 2021 for this centre. Two of these notifications involved instances where the vocalisations of a resident, which were directed at staff, caused other residents present to become upset. These were similar to some the more recent incidents reviewed on this inspection. As the more recent incidents were not being regarded as safeguarding concerns, this suggested that safeguarding procedures in this centre were not being implemented consistently. Regulatory actions around safeguarding procedures had also been raised specifically around similar issues during the two previous HIQA inspections of this centre in January 2022 and September 2020 but based on the evidence of this inspection this remained an area for improvement.

Aside from such matters, fire safety was also reviewed during this inspection. As referenced earlier in this report the designated centre was provided with fire safety systems while staff spoken with were aware of the evacuation procedures to follow. Despite this some improvement was found to be required. Fire drills were being conducted regularly in the centre but it was noted that for some drills where an evacuation time was recorded, some residents were indicated as not refusing to take part in the drills. The inspector reviewed the personal emergency evacuation plans (PEEPs) of such residents. PEEPs are intended to provide guidance to staff in supporting residents to evacuate the centre if required. However, for the residents who had refused to take part in some drills, there was no information outlined in their PEEPs on how to support the residents to evacuate if they refused to leave the centre. Risk assessments relating to these residents and fire safety had not reviewed to take account of their refusal to participate in some drills.

In addition, some residents' PEEPS had not been reviewed in over 12 months while an overall fire evacuation procedure document for the centre had last been reviewed in September 2020 and referenced two residents who no longer lived in the centre. It was indicated to the inspector that three staff were to be on duty at night and fire drills had been done to reflect times when three staff would be on duty. However, it was highlighted that there could be times when only two staff would be on duty and a fire drill had not been done to reflect such times. It was also indicated that when drills were done to reflect times when only three staff would be on duty, residents who participated in the drills would be based in communal areas of the centre. As such a fire drill had not been done to reflect times when staffing levels would be at their lowest and residents would be in their bedrooms. Given their needs, some residents would require additional support and time to evacuate from their bedrooms if required.

The needs of residents were outlined in their personal plans, a sample of which were reviewed by the inspector. These were found to have been recently reviewed and contained information on how to support residents' assessed needs such as around their health. There was evidence that such needs were being supported in the centre with residents supported to attend appointments with general practitioners and dentists while also availing of national screening services. Residents were supported to be involved in the development and review of their

personal plans through a person-centred planning process where priorities were identified for residents such as attending concerts. It was indicated to the inspector that the provider had recently introduced a new person-centred planning process with the recently appointed person in charge undergoing training on this on the day of inspection. Despite this the inspector did note that for some priorities previously identified it was unclear how they were progressed. For example, one resident had identified a priority identified in March 2022 around attending a family member's grave throughout the year. A log of visits to this grave maintained indicated the resident had done this once in the intervening time.

Regulation 18: Food and nutrition

Facilities were provided for food to be stored in and prepared. All meals were made in the centre and residents were asked for their choice around meals.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk assessments around fire safety and certain residents had not been reviewed to take account of some residents' refusal to take part in fire drills.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While the centre was largely clean, issues with storage were noted during the inspection which did not promote infection prevention and control practices. For example, sanitary products were stored in rooms designated as sluice rooms and some laundry was drying beside a mop bucket. Some cleaning was needed in the centre's laundry room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Some residents' PEEPS had not been reviewed in over 12 months and did not include guidance on how to support residents in the event that they refused to

evacuate. An overall fire evacuation procedure document for the centre had last been reviewed in September 2020 and referenced two residents who no longer lived in the centre. A fire drill had not been done to reflect times when staffing levels would be at their lowest or when all residents would be in their bedrooms.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had personal plans provided which were informed by a person centred planning process. However, for some priorities previously identified it was unclear how they were progressed

Judgment: Substantially compliant

Regulation 6: Health care

Residents' health needs were monitored and guidance was in place on how to support residents' assessed health needs. Support was given to residents to attend appointments with general practitioners and dentists. Access to national screening services was also facilitated.

Judgment: Compliant

Regulation 8: Protection

Some incidents where residents were negatively impacted were not considered as safeguarding concerns. As similar incidents previously had been, this suggested an inconsistent approach to safeguarding procedures within this centre. Regulatory actions in this area had been previously identified during the September 2020 and January 2022 inspections of this centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Lios Mor OSV-0004745

Inspection ID: MON-0039924

Date of inspection: 10/05/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • We will endeavor to maintain staffing levels of 5 staff by day and 3 staff by night as set out in the Statement of Purpose. • Contingency plan is relief staff and, if not available, we will link with areas locally or across the wider Limerick Services to cover the vacancy. • The Risk Assessment around meaningful activities has been reviewed and risk rating reduced to an 8 due to one Person supported, who had high support needs, passing away and 6 Person supported now attending day service.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Unannounced management visits by either PIC, Area Manager or Head of Community Services will take place at least three times per month, in addition to planned visits such as staff meetings and supervision. • These visits will focus on engagement with staff and observation of work practices. • A record will be kept of unscheduled visits outlining the date, time and who facilitated the visit. • These visits commenced on the 17th of May 2023. • Designated Officer, PIC and PPIM met with day and night staff on 5th July to discuss the safeguarding policy, the responsibilities of staff in reporting, reporting requirements for safeguarding and accidents and incidents. • In Q4 the reporting responsibilities of staff will be on the agenda for all staff support and supervision engagements within the BOCSILR.	

Regulation 23: Governance and management	Not Compliant

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

• PIC's office is based in Liosmor. PICS shift pattern has now changed to ensure that the PIC is on duty for part of night duty roster at least once a fortnight, to ensure that night staff have an opportunity to discuss any issues they may have and to provide support.
• PIC has commenced night staff meetings in addition to day staff meetings, which are held monthly. The day and night time staff meeting commenced on the 29th May 2023.
• Unannounced visits by PIC, Area Manager and Head of Community Service to take place at least 3 times a month, commencing on the 17th May 2023.
• In addition, quarterly supervision meetings are held with all staff to ensure they have adequate support and supervision in order to fulfil their roles effectively.
• Safeguarding is on the agenda of every staff meeting. At the staff meeting in June 2023, PIC discussed the roles and responsibility of staff, the importance of timely reporting of any concerns by all staff members and ensuring AIRS are completed accurately and completely and escalated where appropriate to manager on call on the day.
• Designated Officer, PIC and PPIM met with day and night staff on 5th July to discuss the safeguarding policy, the responsibilities of staff in reporting, reporting requirements for safeguarding and accidents and incidents.
• Review of staff rosters is underway with a view to increase the rotation of day and night staff to improve oversight and performance management of all staff.
• Template to be developed to facilitate formal written handover to communicate incidents, safeguarding concerns or any health related matters occurring on the shift to PIC/CNM1 and staff on duty.
• Annual governance meeting of Lios Mor involving the PIC and three PPIMs took place on 5th July 2023 and recent report and feedback were discussed together with annual review and last unannounced inspection report.
• There will be shared learning from HIQA reports and 6 monthly provider audits at Area Manager meetings commencing in September 2023. This group is chaired by the Head of Community Services.
• The Designated Officer will meet with the Community Team on a bimonthly basis to discuss safeguarding and share learning.
• Safeguarding training provided by the Designated Officer for all PICS and PPIMS took place in June 2023.
• Training in notification of incidents will be delivered to all PICs and Centre Administrators in September 2023 PIC meeting.
• In Q4 the reporting responsibilities of staff will be on the agenda for all staff support and supervision engagements within the BOCSILR.
• Meeting to be arranged by HR following trust in care processes with management team, HR and designated officer to review learning for the organization.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• Service Agreement has been put in place for resident who moved to Lios Mor in December 2022.

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 has been reviewed and staff compliment updated.
• A copy of the most recent registration certificate has been included with the Statement of Purpose.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All 3 day and quarterly notifications will be submitted in accordance with the regulations.
• All disciplinary sanctions will be notified to the regulator via an NF07. Two NF07s have been submitted retrospectively.
• The requirement to submit an NF07 for staff who are involved in a disciplinary process is included in the advanced safeguarding training that took place on 21st June 2023.
• Training in notification of incidents will be delivered to all PICs and Centre Administrators in September 2023 PIC meeting.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Risk Assessments developed for two residents who had a history of refusing to participate in fire drills and control measures to mitigate the risk put in place.
• All residents' PEEPs have been reviewed and updated, where required, to include guidelines on how to support resident in the event of refusal to evacuate.
• Fire Evacuation Packs with motivators in place for two residents with a history of refusing to participate in fire drill.
• Fire Evacuation Procedure for the centre was reviewed and updated. Fire engineer visited the centre on 06/06/2023 to review fire safety measures and fire evacuation procedures. His recommendations have been included in the centre risk assessment around fire evacuation.
• Minimum staffing fire drill carried out on 17/05/2023 @ 07:00 hours. The fire drill took 4 Minutes 10 Seconds .The next fire drill with minimum staffing is scheduled to take place on the 12th July 2023.
• Further risk reduction in relation to Fire prevention has taken place in the centre by reallocating all laundry duties to day time. The laundry will not be used for washing or drying clothes past 8pm in the evening.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Sluice room has been emptied of sanitary products and clothes airer removed from the area.
• Storage units to be fitted in all bathrooms to store sanitary and incontinence wear.
• Insulated shed to be erected outside Liosmor to provide additional storage.
• Facilities Manager did a walk around of the building with PIC to highlight issues in relation to premises, which may have an impact on IPC. New flooring to be installed in laundry room and painting to be carried out where necessary.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• All residents' PEEPs have been reviewed and updated, where required, to include guidelines on how to support resident in the event of refusal to evacuate. • Fire Evacuation Packs with motivators have been put in place for two residents with a history of refusing to participate in fire drill. • Fire Evacuation Procedure for the centre was reviewed and updated. Fire engineer visited the centre on 06/06/2023 to review fire safety measures and fire evacuation procedures. His recommendations have been included in the centre risk assessment around fire evacuation. • Minimum staffing fire drill carried out on 17/05/2023 @ 07:00 hours.

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: • PCP goals are discussed at weekly house meetings and prioritized for activities for the coming week. • In discussion with person supported, it was decided that he would like to visit family grave at least 3 times in the year, at a time of his choosing. This will be facilitated and recorded. • PIC will review tracking of goals monthly to ensure compliance.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • A review of AIRS was carried out by Designated Officer for the resident concerned. It was noted in this review that there are observable trends of increased vocalisation when the resident is suffering from pain. It was further identified that there are gaps in the information recorded by staff on many AIRS forms, for example, the location of the incident, whether residents witnessed or overheard same or not, and if so what resident, the nature and duration of impact, if present and the resolution of the issue. The outcome of this review was that a further briefing will be provided to all staff; that a protocol for timely administration of the appropriate medication was introduced, that staff are met with by PIC to emphasize and remind them of the need to contact a manager by phone to report an incident, and that the PIC /CNM will be given protected time to review AIRS for any concerning trends before sign off of incidents. • Designated Officer, PIC and PPIM met with day and night staff on 5th July to discuss the safeguarding policy, the responsibilities of staff in reporting, reporting requirements for safeguarding and accidents and incidents.	

• Any incident which results in the breach of a resident's human rights, civil liberties, physical and mental integrity, dignity or general wellbeing will be considered a concern for safeguarding and reported accordingly.
• Full MDT including the Designated officer took place on 4th July to review one resident and safeguarding plan was agreed.
• Risk management in place with quarterly review, at a minimum, of all risk assessments relating to behaviours that challenge.
• Designated Officer provided advanced safeguarding training to managers, including PICs and PPIMS on the 21/6/2023 in relation to safeguarding and reviewing AIRS.
• Safeguarding is on the agenda of every staff meeting and at the next staff meeting in June 2023, PIC will discuss the roles and responsibility of staff, the importance of timely reporting of any concerns by all staff members and ensuring AIRS are completed accurately and escalated to manager on call on the day. Staff are continuously reminded that they can approach the centre manager privately at any time to report safeguarding matters safely.
• Weekly review of AIRS by PIC or deputy to commence to ensure they are completed properly and completely and monthly AIRS report will continue to be sent to Area Manager for review and approval.
• Staff are continuously reminded of their right to submit form CP1 in relation to any incident, regardless and independent of the view of centre management and this will be subject to a preliminary screening by the DO. This is set out in the organisation's policy.
• Review of staff rosters is underway with a view to increase the rotation of day and night staff to improve oversight and performance management of all staff.
• Template to be developed to facilitate formal written handover to communicate incidents, safeguarding concerns or any health related matters occurring on the shift to PIC/CNM1 and staff on duty.
• Training in notification of incidents will be delivered to all PICs and Centre Administrators in September 2023 PIC meeting.
• In Q4 the reporting responsibilities of staff will be on the agenda for all staff support and supervision engagements within the BOCSILR.
• There will be shared learning from the 6 monthly provider audits and HIQA inspections between centres, at monthly PIC meetings and Area Manager meetings commencing in Sept 2023.
• The Designated Officer will meet with the Community Team on a bimonthly basis to discuss safeguarding and share learning.
• Meeting to be arranged by HR following trust in care processes with management team, HR and designated officer to review learning for the organization.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/06/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2023
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	Not Compliant	Orange	30/06/2023

	and effectively monitored.			
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.	Not Compliant	Orange	30/06/2023
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	25/05/2023
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 responding to emergencies.	Substantially Compliant	Yellow	30/05/2023
Regulation 27	The registered	Substantially	Yellow	30/09/2023

	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.	Compliant		
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	10/06/2023
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.	Not Compliant	Orange	30/06/2023
Regulation 03(1)	The registered provider shall prepare in writing	Substantially Compliant	Yellow	25/05/2023

	a statement of purpose containing the information set out in Schedule 1.			
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	25/06/2023
Regulation 31(1)(g)	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 of misconduct by the registered provider or by staff.	Not Compliant	Orange	25/06/2023
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be	Not Compliant	Orange	31/07/2023

	notified under paragraph (1)(d).			
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/06/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/06/2023
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	30/06/2023