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:	L'Arche Ireland - Kilkenny (An Solas/Chalets)
Name of provider:	L'Arche Ireland
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	19 July 2024
Centre ID:	OSV-0003419
Fieldwork ID:	MON-0035795

About the designated centre

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

L'Arche Ireland - Kilkenny (An Solas/Chalets) consists of a large main house and two smaller houses located in a small town setting. The larger house can provide a home for up to four residents and also provides bedrooms for volunteers working for the provider. This house also contains a kitchen/dining area, sitting room, sun room, staff office, prayer room, bathroom facilities and a utility room. The smaller houses are each divided into two separate chalets. Each chalet provides a home to one resident and includes a living/dining area, a bedroom and a bathroom. The centre provides 24 hour care and support for those who have mild to severe intellectual and physical disabilities, over the age of 18 years, both male and female. The centre can accommodate a total of eight residents. Support to residents is provided by paid staff members and live-in volunteers in line with the provider's model of care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Friday 19 July 2024	10:30hrs to 17:30hrs	Miranda Tully	Lead

What residents told us and what inspectors observed

This inspection was completed to review progress made by the registered provider following a previous inspection of the centre in January 2024. The Chief Inspector of Social Services issued a caution in response to the high levels of non-compliances in key regulations found on the unannounced inspection of L'Arche Ireland – Kilkenny (An Solas/Chalets). L'Arche Ireland provided written assurances to improve the standards of care and support in the centre and come into compliance with the Health Act.

During the inspection, the inspector had the opportunity to meet with residents, staff and senior management. In addition, the inspector completed an inspection of the premises and reviewed pertinent documentation. It was evident that the provider had implemented key actions set out within the compliance plan however further improvements were required to ensure actions were in compliance with the Health Act..

The inspector spoke with and observed residents going about their daily routines. Residents expressed to the inspector that they were happy living in the centre and felt supported by staff. Staff were observed responding to residents and interactions between residents and staff were seen to be respectful and engaging.

On arrival to the centre, the inspector was greeted by a number of residents, residents presented the inspector with a card welcoming them to their home. The residents took time to greet the inspector before continuing with their daily plans. One resident had already left the service to attend day service, the resident was not due to return to the centre as they had planned to visit with family. Other residents were seen to prepare lunch with staff support, while others completed shopping lists and went for coffee. The inspector met one resident in their home, they were preparing themselves a snack at the time. The resident informed the inspector that they were moving home in September and asked how long that would be. Another resident returned to the centre later in the day after spending time in the city with staff. The resident was observed playing football in the garden in the afternoon. Overall, residents were seen to be actively engaged in the running of their home and participate in a range of activities.

This centre consists of a large main house and two smaller houses located in a small town setting. The larger house can provide a home for up to four residents and also provides bedrooms for volunteers working for the provider. The smaller houses are each divided into two separate chalets. At the time of inspection there were seven residents living in the centre and one vacancy.

On a walk round of the premises, the inspector observed areas which required painting, flooring which required repair as it was impeding the smooth opening and closing of a door. Two residents had recently transferred bedrooms. This was the second time the residents had changed bedrooms in the centre in recent months, in

addition both residents were awaiting transition to other services. It is recognised that the provider has submitted an application to vary conditions of registration to support changing needs of residents in the future however poor oversight and planning was observed for the two above mentioned residents.

The inspector found that further improvements were required to ensure the systems in place within the centre were appropriately assessing and managing specific resident risks and informing safeguarding procedures.

The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

There was a defined governance structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge was supported in their role in the centre by a house leader.

The local management team were found to be familiar with residents' care and support needs and were motivated to ensure residents were happy, well supported, and safe living in the centre. However, findings on this inspection indicated that improvements were required in the governance and oversight systems.

The provider's systems required improvement to ensure they were effective at capturing areas where improvements were required and that such improvements were implemented and sustained.

Regulation 15: Staffing

The inspector reviewed samples of the roster and found there was a core staff team in place supplemented by a group of live in assistants which ensured continuity of care and support to residents. On the day of the inspection, the registered provider had ensured that there were sufficient staffing levels to meet the assessed needs of the residents. Paid staff members were available to residents 24 hours, seven days a week. A sample of staff files were reviewed and contained information and documents specified in Schedule 2.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The staff team in the centre had up-to-date training in areas such as fire safety, safeguarding and first aid. Where refresher training was due, there was evidence that refresher training had been scheduled. Staff were supervised appropriate to their role.

Judgment: Compliant

Regulation 23: Governance and management

The previous inspection of this centre had identified that the provider's governance systems in place had not ensured service delivery was safe or effective. The provider did not have effective systems in place for comprehensive assessment of residents social, personal and health needs and systems in place were not effective in appropriately managing risks within the centre. On this inspection the inspector found that the provider had reviewed and had prioritised a number of areas such as engaging and implementing individual assessment and plans for individuals, review of policy and procedures and also review of risk management plans.

However, improvements were required in the overall governance and management of the designated centre. While progress had been made following the previous inspection in January 2024, further time was required to ensure systems were effective at capturing areas that required improvement and such improvements were implemented.

A review of the provider unannounced visit completed in April 2024, noted a number of key regulation findings as 'to be determined' including individual assessment and personal plan, health, resident's rights, general welfare and development, fire precautions and premises. In addition, no action plan and/or progress report/follow up was in place for the inspector to review to evidence progression in these areas.

While a copy of the an annual review of the quality and safety of care was made available to the inspector, a copy was not made readily available to residents in the centre.

As noted previously, two residents were scheduled to transition out of this service, there had been protracted delays with both transitions for these residents. Interim arrangements had been implemented for residents to ensure safety. The inspector found improvements were still required in the overall assessment and planning for residents, this is further discussed under individual assessment and personal plan.

Judgment: Not compliant

Quality and safety

A number of improvements were required to ensure that the quality of the service provided was appropriately monitored and to ensure that the residents could enjoy a safe service in their home.

Residents were supported by a staff team who were for the most part familiar with their needs and preferences. Improvement was required in individual assessment and personal plan, the management of risk within the centre, safeguarding and premises.

Regulation 17: Premises

Overall, the premises was well presented and homely. The centre consists of a large main house and two smaller houses located in a small town setting. The larger house can provide a home for up to four residents and also provides bedrooms for volunteers working for the provider. The smaller houses are each divided into two separate chalets.

The provider submitted an application to vary conditions of registration in the days prior to the inspection. The purpose of the application was to allow for increased capacity within the main house in times when residents require increased support or there is a change in needs.

On review of the premises a floor required review in one chalet as it was impeding the closure of the door which was located on a protected exit way. The provider was aware and repairs were scheduled for the day of the inspection. In addition, painting and minor repairs were required in areas of the centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider and person in charge were for the most part identifying safety issues and putting risk assessments in place. Improvements to risk management had been implemented since the previous inspection, however further improvements were required. The inspector found that personal risk assessments were not adequately reviewed to ensure identified risk aligned to the control measures in place and remained appropriate and relevant to earlier identified risks. For example, the supervision arrangements for a resident had reduced with the resident now

accessing the community for periods independently, however the reduction of the risk and rational for a change in control measures was not clearly documented.

The previous inspection found that a risk in relation to a resident's financial vulnerability was not appropriately managed, this was found on this inspection also as the provider continued to have no demonstrable oversight of the residents finances.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

On the previous inspection in January 2024, it had been identified that the provider could not in the long term support two residents to reside in the centre due to a change in needs and due to the then assessed needs of another resident. Both residents remained living in the centre on the day of the most recent inspection. The inspector acknowledges there are planned transitions for both residents however there had been significant delay in these transitions. One resident, enquired to the inspector how long the transition would be and appeared eager for it to progress. On review of incidents, this resident had sustained a significant fall in June 2024. The provider had implemented measures to address the risk to the resident, however this resulted in additional moving for the resident within the centre prior to their long term move.

On this inspection, the inspector observed improved practices in relation to assessments for individuals, however gaps remained in the assessment information available. For example, individual health needs were not included in a residents personal plan.

Judgment: Not compliant

Regulation 8: Protection

The provider had implemented improved safeguards following assessment and guidance for one individual, with the implementation of safeguarding plans, however as noted previously improvements remained in terms of appropriate risk management and safeguarding.

For example, the registered provider had no demonstrable oversight of one resident's finances, despite a clinical assessment indicating the resident did not have the capacity at that time to manage their finances safely. This was previously identified on inspection in January 2024 and appropriate action had not been taken by the provider based on the inspection findings.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for L'Arche Ireland - Kilkenny (An Solas/Chalets) OSV-0003419

Inspection ID: MON-0035795

Date of inspection: 19/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The unannounced internal inspections will have the Action plan completed by the auditor for each inspection from the 30th November 2024 • The internal action plan will be completed and updated within 3months of the inspection, by the provider. • The Annual review will be given at residents meetings starting the week 9th September. • Following an unsuccessful recruitment process to allow for the safe transfer to another centre within L'Arche, a experienced qualified member of the day team will move to residential to allow for the safe transfer by the 16th September. • Active recruitment and retention practices in place ensure that there is a sufficient team in place to provide safe and effective support • The safe transfer of the second resident to a service that can support her assessed needs is now in a trial period and will be completed with the resident moving into her new residential placement - estimated to be 31st October	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The floor was repaired on the 22nd July • The floor will be re-sanded by the 30th November • Minor repairs- tap was repaired on the 30th July • Painting one chalet- will be completed by the 30th November • The system of notifying minor repairs is in place and repairs are dealt with in a timely manner.	
Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• Risk Assessment was updated by the 2nd of August.

• Following discussion the resident has agreed that a member of staff will review their bank account – in place
• A nominated member of staff will review a current bank statement by the 1st October
• The resident currently does not have access to online banking and work has started to get controlled online bank access to facilitate oversight by 18th October
• Active conversation with the family who have access to the resident's bank details
• The principle risk of abuse was removed- online- as the resident voluntarily gave up the smart phone in Jan 2024 and is not on any social online platforms at this time
• With the consent of the resident, they are accompanied in and out of day service and to all other places outside the local area, to reduce the opportunities for other financial and other risks.
• Regular/ Weekly check in times take place to ensure that there is active communication and support available to the resident, to assist in reducing the risk of poor choices and to assist in detecting if the resident requires more support in this area.
• As the danger of financial abuse is more likely to occur when the resident is in poor mental health, support has been given in this area, with MDT team involvement and treatment which started in March 2024, has had a positive result.
• The resident is in the process of exploring a new residential placement and a trial plan is in place with the new service provider. The first visits and overnight stay started 5th August. The new service provider has been informed of all the risk concerns in relation to this resident and different risk reduction strategies that we have in place at meeting on the 17th July and 7th August. We will continue to support the resident and provide all the information available– both verbally and through care and personal plans to the new provider in order to ensure a safe and effective transfer.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

Residents Personal Care Plans have been updated to ensure all relevant Health care needs are documented. Completed 21/08/2024
The admission committee with experienced senior staff and external members with significant experience in health and social care had its first meeting in May.
An admission committee will be held by the 30th October to discuss planning for new admissions in line with the admission policy
The committee will meet on a regular basis as required to guide all new admissions and to analysis all information received, to ensure that L'Arche is the best fit for the person and that we have the resources to provide safe and effective support.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The financial risk assessment had been reviewed frequently, last review the 5/6/2024. The safeguarding plan was reviewed re finances on the 17th July. Both reflected that the key risk of abuse- online had been greatly reduced as the resident had voluntarily given up the smart phone in Jan 2024 and has not requested since.

Other safeguarding processes are in place since Jan 2024 and remain in place-

- Following discussion the resident has agreed that a member of staff will review their bank account – in place
- A nominated member of staff will review a current bank statement by the 1st October
- The resident currently does not have access to online banking and work has started to get controlled online bank access to facilitate oversight by 18th October
- Active conversation with the family who have access to the bank details
- Removal of principle risk of abuse- online- as the resident no longer has a smart phone and is not on any social platforms at this time
- The resident is accompanied in and out of day service and to all other places outside the local area.
- Regular/ Weekly check in times take place to ensure that there is active communication and support available to the resident to assist in reducing the risk of poor choices and to assist in detecting if the resident requires more support in this area.
- As the danger of financial abuse is more likely to occur when the resident is in poor mental health, support has been given in this area and a change in medication has had a positive result.
- The new service provider has been informed of all the safeguarding concerns in relation to this resident and different safeguarding strategies that we have in place, through meetings on the 17th July and 7th August and have been given the relevant reports and information.
- Active support is being provided to the resident and the new service provider during this trial time and all assistance will be given to ensure a safe and effective discharge and admission to the new service.
- Support and training has been provided to the resident on the dangers of financial abuse by her day service and discussed with the resident by her residential team.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/11/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/10/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Not Compliant	Orange	18/10/2024

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/10/2024
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	21/08/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	18/10/2024