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:	Renua
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	24 April 2023 and 25 April 2023
Centre ID:	OSV-0003500
Fieldwork ID:	MON-0030243

About the designated centre

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

Renua is a residential home located in Co. Kilkenny. The service has the capacity to provide supports to three adults over the age of eighteen with an intellectual disability. The centre currently caters for three residents. The service operated on a full-time basis with no closures, ensuring residents are supported by staff on a 24 hour 7 day a week basis. Residents were facilitated and supported to participate in range of meaningful activities within the home and in the local and wider community. The property presents as a bungalow on the outskirts of a large town. Each resident has a private bedroom, with a shared living area space. The centre also incorporated a spacious kitchen dining area and a large garden area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Monday 24 April 2023	12:30hrs to 17:30hrs	Miranda Tully	Lead
Tuesday 25 April 2023	09:30hrs to 13:30hrs	Miranda Tully	Lead

What residents told us and what inspectors observed

This announced inspection was completed to inform a decision regarding the renewal of registration for this designated centre. The inspection was completed over two days by one inspector. Three other inspections were also completed over that time frame in other centres operated by the registered provider. Some overarching findings in relation to the provider's oversight and governance and management arrangements were identified in all four centres inspected, in addition to, improvements required in financial safeguarding and the management of resident possessions. This report will outline the findings against this centre.

On arrival to the centre the inspector was greeted by a resident and staff member. The inspector was directed to a hall table which contained a visitors book and personal protective equipment (PPE) if required. The inspection was facilitated by the person in charge who had been appointed to the role within the previous six months. The inspector also had the opportunity to meet with the person participating in management (PPIM) on the second day of inspection. The PPIM had too been recently appointed to the centre.

Over the course of the two day inspection, the inspector had the opportunity to meet with all three residents that lived in the centre. All three residents used different forms of communication such as vocalisations, gestures and expressions. In addition to speaking with residents, the inspector observed daily routines with residents, spent time discussing residents' specific needs and preferences with staff, met with resident representatives and completed documentation review in relation to the care and support provided to residents. Overall, it was found that the care and support was person-centred and in line with the residents' specific needs.

The staff who spoke to the inspector were knowledgeable regarding residents' needs. Staff spoke about residents' individual needs and preferences and how they as staff respond. Residents were observed to request drinks, relax in their rooms with sensory items and freely move around their home. Staff described the social interactions which the residents engaged in, examples included shopping for items for their home, walks in the local area, visits with family and they also spoke regarding commencement of social farming for one resident.

As this inspection was announced, the residents' views had also been sought in advance of the inspector's arrival via the use of questionnaires. Three residents with staff support used these documents to provide information on the care and support being provided within the centre. Residents expressed they were happy and satisfied with the service being provided. Residents described how they enjoyed the garden, location of the centre as it was close to amenities and the activities which they engaged in.

In summary, based on what the residents communicated with the inspectors and what was observed, it was evident that the residents for the most part received a

good quality of care and support. However, there were areas for improvement which included, governance and management, finance arrangements and some aspects of infection prevention and control practices.

Capacity and capability

There was a clearly defined management system in place which ensured the service provided a good quality of safe care. However, some areas for improvement were required in governance and management. Oversight, in particular audit and monitoring required improvement to ensure it was resulting in a thorough and effective quality assurance system. In addition improvement was required in the effective monitoring of resident finances and management of resident possessions.

There was a clear management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge reported to a community services manager, who in turn reported to the Director of Services.

On the day of inspection, there were sufficient numbers of staff on duty to support residents' assessed needs. From a review of the roster, it was evident that improvements had been made to ensure continuity of care and support to residents. Where possible, the same agency staff were selected to cover shifts. In addition to this a regular relief staff and the person in charge were also covering absences as required. There were two staff present in this centre during the day and one staff present at night. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner.

There were systems in place for the training and development of the staff team. From a review of records, it was evident that the staff team in the centre for the most part had up-to-date training however there were a small number of gaps.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained all of the information as required by the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

Since the last inspection there had been a change in person in charge in the centre. On review of relevant documentation there was clear evidence the person in charge was competent, with appropriate qualifications and skills to oversee the centre and meet its stated purpose, aims and objectives. The person in charge demonstrated good understanding and knowledge about the requirements of the Health Act 2007, regulations and standards. The person in charge was familiar with the residents' needs and could clearly articulate individual health and social care needs on the day of the inspection. Since the last inspection the remit of the person in charge had reduced. The person in charge was responsible for one other designated centre located close by and divided their time between both centres. The person in charge was also working as part of the daily staffing compliment in the centre.

Judgment: Compliant

Regulation 15: Staffing

On the day of the inspection, the registered provider ensured that there were sufficient staffing levels to meet the assessed needs of the residents. There were two staff during the day and one staff at night. Due to vacancies and leave within the existing staff team, relief and agency staff were utilised to ensure there was sufficient staff on the rota. There were currently four different agency staff in use in the centre. Efforts were being made to ensure continuity in care and familiar agency usage. From a review of the rota this was evident in the previous weeks prior to inspection.

An additional member of the inspection team reviewed staff files and rosters at the provider's main office. For the most part staff files were found to contain the information required by regulation. Planned and actual rotas were also maintained and found to contain the required information.

On-call arrangements were in place and communicated to staff to ensure access to managerial support at times when this may be required.

Judgment: Compliant

Regulation 16: Training and staff development

The staff were supported and facilitated to access appropriate training including refresher training that was in line with the residents' needs. A staff training schedule was in place which also included oversight of agency staffs training needs. A training department was in place to ensure staff were notified of any upcoming training or refresher training needed. The staff team in the centre had up-to-date training in areas including infection prevention and control, fire safety, safeguarding, human

rights and manual handling. A number of staff including agency staff required updated refresher training in areas such as managing behaviour that is challenging, safeguarding, managing feeding, drinking and swallowing.

Judgment: Substantially compliant

Regulation 22: Insurance

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The person in charge reported to the Community Services Manager, who in turn, reported to the Director of Services.

Provider level audits and reviews as required by the regulations had been completed however, a clear action plan and progress was not evident to ensure timely improvement in the overall quality and safety of care. The most recent six monthly audit was a new format, and had taken place over a number of months with sections completed by varying persons, some of which were announced. The audit commenced in January 2023 however the person in charge received the completed audit in March 2023. In addition the provider audits were not consistently identifying areas which required review. In particular, the oversight of resident finances and management of personal possessions. This is further discussed under Regulation 12.

It is recognised that the provider is working to establish systems across the service however such systems are yet to be embedded in order to see an effective quality assurance system.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which accurately outlined the service provided and met the requirements of the regulations.The statement of purpose clearly described the model of care and support delivered to residents in

the service. It reflected the day-to-day operation of the designated centre. In addition a walk around of the property confirmed that the statement of purpose accurately described the facilities available including room size and function.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of notifications submitted to the Office of the Chief Inspector occurred. For the most part all notifications were submitted as required.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and provided person-centred care to the residents. A number of key areas were reviewed to determine if the care and support provided to residents was safe and effective. These included meeting residents, their representatives and the staff team, a review of finance systems, risk documentation, fire safety documentation, and protection against infection.

The residents were protected by the polices procedures and practices relating to safeguarding in the centre. Staff for the most part had completed training and were found to be aware of their roles and responsibilities in relation to safeguarding. The residents were observed to appear comfortable and content in their home.

Relevant risks were discussed with the inspector on the day of inspection. A risk register was in place to provide for the ongoing identification, monitoring and review of risk.

As noted previously improvements were required in finance arrangements and the management of residents' possessions. The systems in place meant that residents had limited control and choice around their finances. In addition, oversight arrangements required improvement for example, financial statements were not part of regular auditing and records of residents' possessions were not comprehensive.

The inspector found that the service provider had systems in place for the prevention and management of risks associated with infection however, some improvements were required. For example, the washing machine was placed next to food preparation areas which did not promote safe and effective infection prevention and control. This was addressed during the course of the inspection. In addition, hand hygiene facilities required review to ensure they were in line with best

practice. The designated centre was visibly clean and well maintained on the day of the inspection.

Regulation 12: Personal possessions

As noted previously improvements were required in finance arrangements and the management of residents' possessions. The systems in place meant that residents had limited control and choice around their finances. The provider had identified that residents did not have access to bank accounts. Some residents within the centre held Private Patient Property Accounts (PPPA). This meant that, at times residents had limited access to finances as it had to be requested through the provider's main central office. As staff were only available during office hours, access to resident monies after these hours was limited. The inspector acknowledges that the provider is reviewing this system however, the issue remained on the day of inspection.

Oversight arrangements of resident's finances also required review, reconciliation of residents' bank statements was not evident in the systems for oversight of finances. Occurrences of double payments were evident and while confirmation such monies had been reimbursed to residents this was two months following the deduction. In addition, a resident had come into arrears over a number of years without clear communication to the resident or their representatives as to how this occurred. The provider was aware of the issue at the time of inspection and was engaging with the resident and their representative to address the issue.

In addition, a comprehensive inventory of residents' possessions was not available to review. While a monthly log of purchases and gifts was maintained, a record of significant purchases such as furniture was not maintained locally.

Judgment: Not compliant

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner and well maintained. The designated centre is a detached bungalow located close to an urban area in Co. Kilkenny.The staff team had supported residents to display their personal items and in ensuring that their personal possessions and pictures were available to them throughout the centre. All residents had their own bedrooms which were decorated to reflect their individual tastes. The garden area was large and overall, well kept with suitable seating available for residents if they so wished to sit outside. The person in charge discussed plans to further develop the garden areas for residents as this was an area of interest. In the previous inspection, works were identified as required to a bathroom . It was evident that this work had been

completed with the addition of a Jacuzzi bath which was reported to have been enjoyed by residents.

Judgment: Compliant

Regulation 18: Food and nutrition

The inspector had the opportunity to be present for a number of mealtimes for residents. It was evident that staff had good knowledge of residents' preferences, dietary requirements and were familiar with residents' specific needs. Staff were observed to prepare drinks and meals in line with the relevant eating, drinking and swallowing plans.

Meal planning was completed with residents weekly at residents' meetings. The proposed menu was on display each day for residents with a varied diet offered. Food was observed to be cooked in the home daily by staff. Residents could access a variety of snacks and drinks during the day and were observed requesting same from staff. Where possible residents assisted in preparing meals and snacks. This was observed during the course of the inspection.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider prepared a residents guide which contained the required information as set out by the regulations.The required information outlined in the residents' guide corresponds with other related regulations specifically the statement of purpose, residents' rights, communication, visits, admissions and contract for the provision of services and the complaints procedure.

Judgment: Compliant

Regulation 26: Risk management procedures

The safety of residents was promoted through risk assessment, learning from adverse events and the implementation of policies and procedures. It was evident that incidents were reviewed and learning from such incidents informed practice. There were systems in place for the assessment, management and ongoing review of risks in the designated centre. For example, risks were managed and reviewed through a centre specific risk register and individual risk assessments. The individual

risk assessments were up to date and reflective of the controls in place to mitigate the risks.

Judgment: Compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for COVID-19 in relation to staffing and the self-isolation of residents. There was infection control guidance and protocols in place in the centre. The inspector observed that the centre was visibly clean on the day of the inspection. Cleaning schedules were in place for high touch areas, regular cleaning of rooms and some personal equipment.

Some systems in place for the prevention and management of risks associated with infection required improvement. For example the washing machine was placed next to food preparation areas which did not promote safe and effective infection prevention and control. This was addressed during the course of the inspection. Flooring was observed to be worn in a bedroom and office area, this had been identified by the provider and was due to be replaced in the coming weeks. Hand hygiene facilities also required review to ensure they were in line with best practice.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. All staff have received suitable training in fire prevention and emergency procedures. There were adequate means of escape, including emergency lighting. For example, escape routes were clear from obstruction and sufficiently wide to enable evacuation, taking account of residents' needs. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. There was evidence of regular fire evacuation drills taking place in the centre.

Judgment: Compliant

Regulation 8: Protection

Notwithstanding issues discussed under regulation 12, residents were protected by

the policies, procedures and practices relating to safeguarding and protection. Staff had completed training in relation to safeguarding and protection and were found to be knowledgeable in relation to their responsibilities should there be a suspicion or allegation of abuse. Residents had intimate care plans in place which detailed their support needs and preferences.

Judgment: Compliant

Regulation 9: Residents' rights

Throughout the inspection the inspector observed residents being treated with dignity and respect. There was information available for them in relation to their rights, complaints and advocacy services. Staff had completed training in Human rights and were observed transferring this knowledge into practice. A previous practice of night time checks had been reviewed ensuring residents' right to privacy was respected.

Residents were also provided with information to help them make choices and decisions in relation to their day-to-day lives.

Judgment: 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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Renua OSV-0003500

Inspection ID: MON-0030243

Date of inspection: 24/04/2023 and 25/04/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. All staff will be trained in managing behaviour that is challenging by 14.09.2023 2. All staff will be trained in managing feeding, drinking and swallowing by 20.08.2023	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1.Action Plan is in place for the current six-monthly audit which was completed on the 24.04.2023. PIC is working on completion of actions with the staff team. Reporting on progression of same through PIC monthly status report to DOS and ADOS. 2. The provider auditing system is a new system, which was implemented in January 2023 and is continually reviewed to develop quality of same. On review it has been identified that auditors across service will need further guidance and mentoring on how to conduct a good quality audit. DOS and Quality Department have agreed that all annual audits will now be completed by the Aurora Lead auditor to ensure a high-quality audit and also full implementation of actions in the designated centre. A meeting took place also to further progress implementation of provider audit system on Viclarity online system by latest 30.10.2023. 3. Aurora Senior Management Team met on 4.5.2023 and 18.5.2023 to discuss and review HIQA feedback from the 4 inspection that took place on 24th and 25th April. An	

action plan was developed and progression of actions reviewed.
Following main actions were agreed at SMT level:
- Interim Governance & Management Plan to ensure PIC cover for all designated centres and change of line management of PICs. Plan was communicated to all relevant personnel on the 17.5.2023 and copy sent to HIQA for information purpose.
- The provider auditing system is a new system, which was implemented in January 2023 and is continually reviewed to develop quality of same. On review it has been identified that auditors across service will need further guidance and mentoring on how to conduct a good quality audit. DOS and Quality Department have agreed that all annual audits will now be completed by the Aurora Lead auditor to ensure a high-quality audit and also full implementation of actions in the designated centre.

4. Review of Aurora Finance policy and oversight on person's finances to safeguard same.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Aurora has developed a Finance Position Paper in February 2023 to outline the challenges re person's bank accounts. This position remains and has been made available to HIQA in February 2023.
Aurora Finance department is implementing a new debit card, Soldo system as Quality Initiative across Aurora for house budgets in June 2023. As a next development Soldo cards will be implemented for people we support.

Aurora Finance Department has reviewed the Schedule 5 policy and also the completion of finance audits to ensure further guidance is provided to all staff teams and managers how to review person's daily spendings and bank statements.
Finance Department has one senior designated auditor to complete audits on provider level to ensure further oversight. Finance officer is also completing fortnightly checks during top up and highlighting any discrepancies directly to PIC, Director of Finance and DOS.

Record of all significant purchases is evident on person's asset list for all people supported in Renua since the 24.04.2023. Communication re adherence to policy was held with staff team by PIC.

Regulation 27: Protection against	Substantially Compliant

infection	

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Following actions have been taken to address IPC issues in Renua:

1. Washing machine next to the food preparation area- moved and addressed -24.4.2023
2.Flooring of bedroom and office to be replaced-completed 09.05.2023
3.Review of hand hygiene facilities- Reviewed by PIC -25.4.2023.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	24/04/2023
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	14/09/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	19/06/2023

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	19/06/2023
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	Substantially Compliant	Yellow	26/05/2023

	healthcare associated infections published by the Authority.			