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:	Port Lodge
Name of provider:	St John of God Community Services CLG
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	09 December 2024
Centre ID:	OSV-0008865
Fieldwork ID:	MON-0045696

About the designated centre

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

Port Lodge is a residential community home that provides 24-hour care and support to adults with mild to severe intellectual disabilities. It is a two-bedroom detached bungalow situated in a quiet rural location.

The house features two large living rooms and a spacious kitchen/dining room. Port Lodge includes two bedrooms, one of which has an en-suite bathroom, as well as a large shared bathroom. Additionally, there is a multipurpose room available. There are gardens located at both the front and rear of the house.

Port Lodge is conveniently located near a village in County Louth, which offers various amenities, including a pharmacy, butcher shop, church, small grocery store, pubs, an Italian restaurant, and several take-away options.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 9 December 2024	09:00hrs to 17:00hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with regulations and standards and to follow up on concerns raised following the receipt of unsolicited information. Concerns raised were in relation to governance and management, staff knowledge and experience and the quality and safety of the care being delivered to residents.

The inspector reviewed nine regulations during the course of the inspection, six were found to be non-compliant, one was substantially compliant, and two were compliant with the regulations. The inspection highlighted issues with the management and general oversight of the service and two urgent actions were required on the day in relation to healthcare and risk. Areas that require improvement will be discussed in more detail later in the report.

Upon arrival at the residents' home, the inspector was greeted by a staff member. The two residents were still relaxing in their rooms and had not yet started their day.

The inspector sat at the kitchen table and interacted with the staff members. Two staff members were on duty; one was based at this house, while the other had been redeployed from another service due to staffing shortages caused by illness. The staff members spoke to the inspector about the residents' routines. The inspector noted that for one resident, there was a list of activities available for their engagement. For the other resident, a staff member explained that physical activity was essential and that the resident enjoyed going for walks each day, which was supported by the staff team.

The inspector was introduced to one of the resident's in the kitchen area. The resident greeted the inspector but appeared unsettled by their presence, prompting the inspector to move to a different location.

Later in the day, the inspector observed the two residents relaxing together in the sitting room with a staff member. One resident was engaging in their ritualistic behaviors, which were important to them. Both residents seemed relaxed in their home and comfortable in their interactions with the staff. The inspector also observed the residents going on outings on two occasions during the inspection, as aligned with their daily routines.

While the inspection found that the residents were being supported to engage in activities they enjoyed and appeared comfortable at home, other findings indicated significant areas needing improvement to enhance the quality of care and support provided to both residents.

The next two sections of this report will present the inspection findings related to governance and management in the centre and how these aspects affect the quality

and safety of the service being delivered

Capacity and capability

On the 3 December 2024, the office of the Chief Inspector received unsolicited information raising concerns about the service provided to residents since the designated centre opened in August. After reviewing this information, a risk-based unannounced inspection was scheduled. The findings from the inspection were not favourable, as the concerns highlighted in the unsolicited information were validated.

One significant issue was that, the existing governance and management arrangements were ineffective. Although a management structure was in place, the inspection revealed poor oversight and inadequate maintenance of information related to the operation of the service and residents' records. Additionally, many staff members lacked up-to-date training in various areas, and both the provider and the person in charge had failed to adequately address the actions identified in previous audits.

However, the inspector noted that the provider had recognised staffing issues and was taking steps to address them.

In summary, the inspection highlighted numerous areas needing improvement. Although the provider identified many of these issues in an audit completed on the 8 November 2024 the response to the audit was insufficient and will be discussed in more detail later in the report.

Regulation 15: Staffing

The inspector reviewed a three-week sample of rosters from August, November and early December. The review of records showed that, the provider had ensured that safe staffing levels were maintained.

There had been a period following the opening of the service that there was not a consistent staff team in place. The person in charge informed the inspector, and the review of the rosters identified that this issue had been addressed with a more consistent team now in place to support the residents.

The provider had also identified a need to enhance the skill mix of the staff team. The inspector was provided with evidence of plans to address this as a second staff nurse was scheduled to join the staff team later this month.

In summary, there had been a period where there had not been a consistent staff

team; the provider had responded to this and was also taking steps to enhance the skill mix of the staff team

Judgment: Compliant

Regulation 16: Training and staff development

The inspector noted that during the review of internal audits conducted in the centre 31 October 2024, four staff members did not have up-to-date fire training. The audit on 08 November 2024, also identified that staff members were lacking all the necessary training. Additionally, the audit revealed that the person in charge did not have a record of the training completed by the staff team.

During the inspection, the inspector requested to review the staff training records. The person in charge informed the inspector that, a completed training matrix had not yet been established and that they did not have access to all the training records. The inspector asked for this information to be provided, however, when the records were provided they were incomplete and they also indicated that, some staff members required training in areas such as fire safety, managing behaviours of concern, and safeguarding. This posed a risk to residents as staff did not have the necessary training to ensure they could deliver appropriate care and support to the residents.

The review of the available information demonstrated that the provider had not ensured that the staff team completed the required training. Furthermore, the provider had failed to supply the person in charge with an accessible record of the staff team's training status.

Judgment: Not compliant

Regulation 19: Directory of residents

During the inspection, the inspector requested confirmation of the admission dates for the residents. Initially, the person in charge was unable to verify the admission date for one resident. When the inspector inquired whether a directory of residents had been established, the person in charge acknowledged that while there was none competed they had started working on it. The review of what was available showed the document did not include the necessary information as outlined in the regulations.

Furthermore, the November audit had identified this issue as needing attention, and the action plan indicated that the directory of residents had been established; however, this was found not to be the case.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector reviewed the management of the service and found the current governance and management arrangements were not effective. Improvements were necessary to the management systems to ensure the care provided to each resident was appropriate to their needs, consistent, and effectively monitored.

The provider conducted an unannounced visit on 08 November 2024, during which an audit assessed the quality and safety of care and support offered to the residents. The audit identified 31 areas that required improvement.

When asked whether an action plan had been developed to track the completion of tasks, the person in charge presented an action plan. The inspector was also informed that the person in charge had been meeting with a member of the provider's senior management team to review the progress of the completion of actions weekly.

Upon reviewing the action plan, the inspector noted that not all actions had been included. 18 actions were listed on the plan despite 31 being identified in the audit. Only 11 actions had been completed by the time of the inspection. Additionally, actions due for completion by 30 November 2024 had not been completed. For example, residents' personal plans had not been updated within 28 days of their admission to the service, and staff training actions were also not completed within the specified time frame.

The inspector expressed concerns that, the findings from the audit had not been adequately addressed at the local management level. Furthermore, discussions during the inspection indicated that senior management believed some actions had been completed, including the two mentioned above. This raised additional concerns about senior management's oversight of practices occurring within the service, despite regular meetings with the person in charge to review the action plan.

The inspector identified further areas of poor oversight of information related to residents. For instance, the inspector found information requesting that a resident be referred for a medical procedure and to attend a mental health appointment. During the course of the inspection, the inspector was not assured that these actions had been addressed. Consequently, the inspector issued an urgent action regarding these issues, and the provider responded by confirming that new appointments had been scheduled.

The day after the inspection, a member of the provider's senior management team submitted information confirming that a referral for the medical procedure had been made following the initial request in July. However, the person in charge was unaware of this referral, nor had they or the staff taken steps to follow up on it.

Subsequent to the inspection, evidence was also provided that, the resident had attended the mental health appointment. However, the notes from this appointment had not been documented by the staff member who attended the appointment and were not available for review during the inspection. These omissions posed a risk to the resident as the required procedure had not been followed up on and staff in the centre were unaware of mental health appointments having taken place.

This demonstrated poor information sharing by the provider, as the referral had been made before the person in charge began in the role and they had not been provided with an adequate hand over of information.

A similar issue was also identified regarding a resident's communication needs and the impact of this will be discussed under regulation 10 communication.

In summary, the inspection process identified a number of issues with the management of the service. Audits had been completed that identified areas needing improvement, but the actions to address these findings had been insufficient. Enhancements were necessary to the management systems to ensure that the service provided to each resident was appropriate, consistent, and effectively monitored.

Judgment: Not compliant

Quality and safety

This inspection identified that, improvements were required regarding the service provided to the residents in a number of areas including responding to the residents' communication needs, risk management upkeep and management of residents' information and ensuring that all fire management and precautions were appropriate.

The report will discuss these issues in more detail in the sections below, but the findings again identified poor oversight and management of information, which was impacting the quality of the service provided to the residents.

A positive finding related to how residents were supported to engage in things they enjoyed and that they were encouraged to engage in activities in their local community. However, the negative findings in the other areas overshadowed this.

Regulation 10: Communication

The inspector discussed the communication aids used to support a resident with a staff member. The staff member explained that the staff team employed verbal

prompts and gestures towards objects, noting that the resident responds well to this approach. However, the inspector learned that there were no communication boards or other visual aids in use for the resident.

While reviewing the resident's information, the inspector found a document titled "Personal Passport," which provided guidance on how to support the resident's communication skills. This document indicated that the resident had a dictionary of objects to express their needs to the staff. When the inspector asked the person in charge if staff members were utilising this dictionary, the person in charge stated they were not aware of it and that it was not in use.

The inspector then inquired whether the resident's communication needs had been assessed. The person in charge did not have this information and sought clarification from senior management. Later that day, the person in charge informed the inspector that a formal communication assessment had been conducted in March of this year. However, the findings from this assessment had not been shared with the person in charge or the staff members currently supporting the resident prior to the inspector's inquiries.

This lack of communication did not demonstrate adequate oversight of the resident's information and indicated that there were ineffective systems in place to respond to the needs of each resident.

Judgment: Not compliant

Regulation 13: General welfare and development

The inspector reviewed the residents' daily notes for the preceding two-week period. There were examples of the residents engaging in their preferred activities. One resident attended a day service program two days per week, and the other was provided with an individualised service from their home.

One of the resident's enjoyed engaging in social activities and going to groups, and there was evidence of them being supported to attend these events and activities, whereas the other resident preferred less social activities and enjoyed going for walks with staff each day.

In summary, there was evidence that the residents were engaging in the things they enjoyed, and on the day of the inspection, the inspector observed the residents to appear comfortable in their home and to be active in their community with the support of staff.

Judgment: Compliant

Regulation 26: Risk management procedures

During the inspection, the inspector identified a significant risk that had not been recognized by the provider. An Aga cooker and stove were located in the kitchen/dining area. While passing by the cooker, the inspector noticed that the covers of both hot plates had been lifted. The inspector found that the surface was hot and that the cooker itself was also hot to the touch, posing a significant risk of burns to residents or staff members. This risk had not been identified by the provider, the person in charge, or the staff team.

The inspector issued the provider an urgent action to address this risk. The provider's maintenance team promptly arrived on-site, and a plan of action to reduce the risk was implemented.

While reviewing the updated risk assessments that reflected the residents' current living arrangements, the inspector noted that a risk control measure for both residents was that all staff members had received appropriate training in managing behaviours of concern. However, this was not the case, meaning that the risk control measures were inadequate.

The inspector acknowledged that, the risk assessments had been updated and did reflect the residents' needs. Interactions with a staff member also demonstrated that the staff member was aware of the risk assessments and how to mitigate potential risks while supporting the residents.

In summary, the inspector found that the provider failed to identify an obvious hazard and risk in the residents' home and did not ensure that the listed risk control measures were in place which had the potential to put resident at risk of harm.

Judgment: Not compliant

Regulation 28: Fire precautions

The review of training records revealed that the provider had failed to ensure that all staff members received up-to-date fire safety training before starting work at the designated centre. Four staff members still needed this training, which had been identified in two separate audits conducted by the provider. Despite this, on the day of the inspection, these staff members continued to work without proper training. This response from the provider was inadequate, indicated poor management and had the potential of putting residents at risk should a fire break out in the centre.

The records indicated that two fire drills had been completed, showing that residents could be evacuated in both daytime and nighttime scenarios. However, there was no evidence that all staff members had participated in a fire drill to demonstrate their ability to safely evacuate residents in the event of a fire. This is

particularly concerning given the staff team was new to working in the building.

The inspector did find that the provider ensured appropriate fire detection, fire fighting, and fire containment measures were in place. The equipment had been checked and serviced by a qualified individual, and the activation of the fire alarm on the day of the inspection confirmed that it was functioning properly.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge is required to prepare a personal plan for each resident that accurately reflects their needs no later than 28 days after their admission to the service. The inspector found no evidence that residents' personal plans were updated since their admissions. One resident moved into the service in mid-August, while the second resident arrived in late October.

Upon reviewing both residents' information, the inspector found that their care and support plans still related to their previous placements. When the inspector sought clarification about the information in the plans, the person in charge stated that certain supports were no longer necessary since the residents' transitions. However, the residents' information had not been updated to reflect this.

This lack of up to date information had the potential to cause harm to residents as the information regarding their care and support needs was not accurate and as a result staff may not know how to support their need appropriately.

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	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Port Lodge OSV-0008865

Inspection ID: MON-0045696

Date of inspection: 09/12/2024

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff have completed fire training by 6/01/2025 The training Matrix for the Designated Centre is up to date and accurate. All future training requirements will be scheduled as identified. 06/01/25 PIC has access to HR training records 9/12/24 All HSEland safeguarding training certs obtained from staff 6/01/2025 The provider is upgrading the staff training platform, in quarter 2 2025, staff training will be conducted on HELM which has similar capabilities to HSE Land and will provide real time data for the PIC.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Directory of Residents has been updated to contain information required as specified in paragraph 3 schedule 3. 10/12/24	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of oversight in the DC has occurred between the PPIM and PIC, shortfalls identified in the report noted and actions to prevent recurrence agreed. 18/12/24

QEP was reviewed by PPIM and PIC, grouped actions were noted and individualized to ensure clarity. 20/12/24

DC meetings between PPIM and PIC scheduled 2/52 with rolling agenda defined.

Peer audit completed on residents plans of care and updated as appropriate. 3/01/25

Full review of local transition documents completed. Process flow for communication between PIC's at transition of residents being developed along with an overhaul of minimum requirement of transition planning taking into account each residents will and preference with support from ADM Coordinator. This will be operational by end of quarter 1, 2025

Follow ups have occurred for any outstanding medical appointments

The PIC to oversee the reviews completed by psychiatrist and ensure all actions are completed. GP appointment 12/12/24 and Psychiatrist review 21/12/24

Team meetings scheduled Monthly where each resident will be discussed with full staff team and all relevant information will be shared. 10/12/24

PIC receiving Buddy Support from experienced peer PIC. 10/12/24

Staff training in Equality and Human Rights scheduled with the staff team 22.1.2025

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
Resident communication aids are in place and all staff are aware of these and support the resident in using them. 10/12/24

Communication Assessment in place, all staff are aware of same and support resident in this area. 09/12/24

Team meetings will include communication as an item agenda

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Aga cooker is no longer accessible to the residents. 9/12/24

One staff outstanding, booked into refresher CPI training on 9/01/2025

All staff have read and understand the residents PBSP. 22/12/24

Health and Safety Officer reviewed measures put in place to mitigate risks identified on day of inspection. 16/12/2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire training for all staff has been completed on 6/01/25

All staff are aware of fire evacuation protocols in Port Lodge.

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:
All IPP's have been audited and updated to reflect accurately the individual care and support requirements relevant to each resident. 18/12/24

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	10/12/2024
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.	Not Compliant	Red	13/12/2024
Regulation 19(2)	The directory established under paragraph (1) shall be made available, when requested, to the chief inspector.	Substantially Compliant	Yellow	09/12/2024
Regulation 23(1)(c)	The registered provider shall ensure that	Not Compliant	Red	06/01/2025

	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.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	16/12/2024
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Red	13/12/2024
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably	Not Compliant	Orange	18/12/2024

	practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			