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:	Unannounced
Date of inspection:	19 February 2025
Centre ID:	OSV-0003500
Fieldwork ID:	MON-0045614

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
Wednesday 19 February 2025	09:00hrs to 18:00hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was carried out with a specific focus on safeguarding, to ensure that residents felt safe in the centre they were living in and that they were empowered to make decisions about their care and support.

Overall, the inspector found that practices within the centre were not optimising residents' safety. A number of improvements were required to ensure residents were safe, they were provided with a rights' based approach to care and support, and that the systems in place both at local and provider level were driving meaningful quality improvement.

The inspector found that there had been a deterioration with levels of regulatory compliance in this centre since the previous inspection.

The designated centre had capacity to accommodate three residents and there were no vacancies on the day of inspection. The three residents have lived together for a number of years.

The inspection occurred over a one day period by one inspector. The inspector used observations, conversations with staff, interactions with residents and review of key documentation to form judgements on the quality and safety of care and support provided to residents.

On arrival at the centre, the inspector was welcomed in by an agency staff member. They explained to the inspector that they were a regular agency staff and had completed a number of shifts in the home and were familiar with the residents. A second staff member was also present at this time.

Two residents were in their room when the inspector arrived and one resident was in the kitchen. A staff member was preparing breakfast for the resident. The resident primarily used non-verbal means to communicate such as facial expressions, body language and some vocalisations. They were carrying a preferred item and were walking around the kitchen. They appeared content and comfortable in their environment.

The staff explained that all residents were leaving later in the morning to go on a community walk. Although the residents did not attend a formal day service they accessed different activities in their local community. Residents in the home enjoyed a variety of activities such as meals out, attending events in their local community such as walking and cycling groups, going to events such as the ploughing championship, horse races and winter light displays and holidays.

Later across the day the inspector met with the other two residents. Again both residents had varying communication styles and mostly used non-verbal cues when in the company of the inspector. For example, one resident would take the inspector

by the hand to bring them to an item they wanted. This resident liked to come in and out of the office area and frequently came in and out of this room during the inspection process.

When the residents came back from their walk they all sat down and had lunch at the kitchen table together. Staff were available to support the residents as required. The residents relaxed in their home for the rest of the afternoon. Although residents freely moved around their home they were supervised by staff. This was to ensure that all interactions between peers remained positive.

When the residents left for the morning the inspector completed a walk around of the premises with the person in charge. The residents lived in a detached bungalow building in a housing estate in Co. Kilkenny. The house was in walking distance to local amenities and the residents also had access to a car to take them out and about in the community. Each resident had access to their own bedroom, two bedrooms had en-suite facilities. There was also a main bathroom, a kitchen and a sitting room.

The residents had a large back garden area. There was a swing seat present and staff explained that one resident in particular really enjoyed the outdoor space. For the most part the garden was in a presentable state, however one part of the garden was quite overgrown, the shed was damaged and there was some indoor furniture that required removal from this area.

On the walk around the inspector noted that the cleanliness and maintenance of the property required improvements in a number of areas of the home. Areas that were difficult to reach such as behind couches, under radiator covers and behind toilets were not cleaned on a frequent basis. In addition, it appeared that the inside of cupboards were not subject to a deep clean with an accumulation of dust and some staining present. Maintenance work was required throughout the home as there was some chipped and/or stained painting, peeling laminate on the kitchen cupboards, damaged kick boards and floors with gaps present. It was essential that the areas were addressed to ensure safe infection protection and control (IPC) measures could be maintained.

The next two sections of the report presents the findings of this inspection in relation to governance and management of this centre and, how the governance and management arrangements impacted on the quality and safety of the service being provided.

Capacity and capability

Overall, the inspector was not assured that the systems for oversight were implemented in a comprehensive or robust manner both at provider and local levels. A number of improvements were required in key regulations such as safeguarding, residents' rights, positive behaviour support and risk, with gaps in oversight

apparent across the regulations reviewed. In summary, the systems of oversight were not providing residents with good quality and safe care at all times. The management systems were failing to identity and implement the necessary changes to bring the centre into compliance with the regulations.

Although there were systems of oversight in place at a provider level such as six monthly unannounced audits and annual reviews the actions identified in these audits were not bringing about the required improvements to drive meaningful quality improvement. In addition there was a lack of focus and follow-up in relation to local level audits and actions plans.

Regulation 15: Staffing

The inspector reviewed the rosters in place in the designated centre for January and February. The residents were supported by two staff members during the day and one waking night staff member at night. Overall the planned and actual rosters were well maintained with full names present on the roster and relevant roles within the organisation. The residents were supported by social care workers and health care assistants.

Regular relief staff and agency staff were utilised to cover staff leave and absences. Overall from a review of the 8 week period the use of agency and relief was kept to a minimum. For example over a two week period in January seven shifts were covered either by agency or relief.

The inspector viewed three staff files and found that they contained all the information as required by Schedule 2. For example, Garda vetting and references were present in the files. The Garda Vetting disclosures for agency staff were also readily available to review.

Staff spoken with on the day of inspection were aware that residents required supervision in communal areas to ensure positive interactions between peers.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix in place for all staff members. On review of this document it was found overall, that the majority of staff had training in areas such as safeguarding, fire safety and first aid. Additionally the staff team had received training to support residents in line with their assessed needs such as epilepsy and feeding, eating, drinking and swallowing needs.

Although all staff members had received the training in the safe administration of

medicines, one staff member required to complete the practical assessments in relation to this training. According to the records reviewed they had completed the online training part in March 2024 and at the time of inspection the assessment piece remained outstanding.

Although some improvement was made in relation to staff receiving supervision, with a number of staff receiving supervision in the latter part of 2024 and early in 2025. From a review of four staff members supervision records their supervision was not occurring in line with the provider's policy. The provider had stated that a minimum of four supervisions were to be held in a calendar year. Out of the four records reviewed not one person had received this level of supervision

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector was not assured that the systems in place for governance and oversight of the centre were comprehensive or effective in driving meaningful quality improvement and addressing issues in a timely manner. There was gaps in oversight both at local and provider level. This resulted in safety issues not being addressed in an effective manner and aspects of quality of care being poor.

Although the provider had six monthly and annual review audits in place and actions were generated in relation to these audits. The audits were not always effective in identifying pertinent issues in relation to risk, safeguarding, positive behaviour support. and residents rights. For example, in relation to access to advocacy this had been identified as a requirement for one resident. The referral had gone in to the relevant agency in June 2023. The annual review and six monthly audits that occurred in 2024 identified that this required follow-up. However, on the day of inspection this had not taken place.

In relation to risk, some identified risks on the day of inspection were not being managed in an effective manner. This is discussed in further detail under Regulation 26. In terms of oversight, there were insufficient systems in place to ensure actions, as identified by the provider, were followed up in an appropriate manner. For example, following a review of two serious incidents in September 2024 the inspector reviewed an email sent from the provider to indicate what actions were needed to be completed. On the day of inspection none of the actions identified had been implemented. There was no follow-up system in place to ensure that the actions identified were completed.

At local level, the systems in place for regularly auditing and reviewing the quality and safety of care were not clear. Although a number of local audits had occurred in 2024 such as medication, hygiene, mattress audit, finance and epilepsy some of these were in complete. For example, one medication audit completed in September 2024 was only half completed and no actions had been generated. Apart from

finance audits there was no schedule in place to when the above audits were to occur in 2025. For example, monthly hygiene audits had occurred from May to September 2024 but there was no evidence of an audit occurring following this. The systems for local oversight required review to ensure they were adequately in place.

Judgment: Not compliant

Quality and safety

Overall it was found that residents appeared comfortable in their home on the day of inspection. However, a number of improvements were required across key regulations to ensure that the service was safe and had a positive impact on residents' quality of life. A number of improvements were required in relation to risk management, positive behaviour support, promoting a rights based approach to care and support and premises condition. Aspects of safeguarding residents finances also required significant improvement.

Although there were systems in place to assess and mitigate risks, the findings of the inspection indicated that these systems were not applied in an effective manner. Therefore a number of risks were not being managed appropriately. Some risk assessments were not comprehensive or updated in a timely manner and they lacked effective control measures. Incidents were not being trended or reviewed in line with best practice. Overall, risk management was poor in the centre.

The condition of aspects of the premises required improvements both from a maintenance and cleanliness perspective. On the walk around of the premises the inspector noted a number of areas of the home that required a deep clean. In addition maintenance works and painting was required in kitchen, hall and bathrooms. Due to the issues present in the home the inspector was not assured that effective IPC measures could be taken and residents were more likely at risk because of this.

Although some safeguarding concerns were being well managed within the centre such as peer-to-peer incidents. Financial safeguarding practices were not applied consistently across the resident group. Although the provider was aware of this little effective actions had been taken to date.

Regulation 10: Communication

Although some good practices were in place around residents' communication needs, such as a communication tool box document. In this document the residents' means of communication was outlined. Residents also had access to telephones and

other media such as internet and television.

However, a communication assessment, in relation to how residents communicate pain and discomfort had not been completed. Although this had been identified in the provider-led audit dated October 2024 this remained outstanding. As many of the residents primarily communicated using non-verbal means it was essential that assessments such as these were completed to ensure the staff team understood when residents were communicating pain or other discomfort.

Judgment: Substantially compliant

Regulation 17: Premises

As previously described the residents lived in a three bedroom bungalow building in a residential area. All residents had their own individual bedroom, two residents' bedrooms had en-suite facilities while the resident could access a main bathroom. The residents also had access to a sitting room and a kitchen come dining room. One room in the home was allocated as a staff office. To the rear of the home there was a large back garden and there was ample parking to the front of the home.

The inspector completed a walk around of all areas of the home. Although some parts of the home appeared clean, hard to reach areas were not afforded the same attention to detail in relation to cleanliness. For example, under radiator covers, behind bins, behind the toilet and at the side of couches there was a build up of dirt and debris. Kitchen and bathroom cabinets had not been cleaned out and there was an accumulation of dirt, staining and dust evident in places. Skirting boards in the kitchen had staining present.

In addition a number of maintenance works was required throughout the home to ensure it was maintained to a good standard and effecitive IPC measures could be taken:

- Kitchen cupboard doors had peeling laminate.
- The kick boards in the kitchen were marked.
- There were gaps in the kitchen flooring were an accumulation of dirt and debris was present as they could not be reached for effective cleaning.
- There was some mould present on the ceiling of the bathroom.
- Some paint work in the home was badly marked with grease and there was some chipped paint in places
- There were sinks present in bedrooms there were not in use and used for storage of clothes or other items. Some of the tiling around these areas was in poor condition.

Judgment: Not compliant

Regulation 26: Risk management procedures

Overall, practices in relation to risk management were not in line with policy or best practice.

On a review of incidents, the inspector noted that incident occurred in November 2023 in a vehicle that posed a significant risk to the resident and the driver of the car. The risk assessment put in place following this incident was was dated April 2024 which five months following the incident. Further similar incidents occurred on 31 of August 2024, 14 September 2024 and the 28 September 2024. Although some of these incidents were reviewed by senior management, and recommendations were made, these had not been implemented. For example, the risk assessment had not been updated. The control measures in place were not effective considering the risk posed and some control measures had not been implemented. There was a lack of effective risk management in relation to these incidents.

In addition, on the walk around of the premises the inspector noted that a chain was in place across an emergency exit door. No risk assessment or other measures had been considered in relation to this risk. Although this was an identified restrictive practice there had been a failure by the provider to effectively consider the risk this measure took in relation to fire safety.

The inspector also noted the storage of some medicinal products such as fluid thickener and wound gel which was not in line with the provider's policy and there was no corresponding risk assessment in relation to the relevant risk.

Judgment: Not compliant

Regulation 7: Positive behavioural support

As part of the safeguarding inspection, the inspector reviewed the measures in place to ensure appropriate supports were in place to manage incidents where residents engaged in behaviour that challenges. The inspector requested the behaviour support plan in place to manage incidents of self-injurious behaviour that were occurring. The behaviour support plan in place had been filed away for archiving and had not been updated since January 2023. Therefore there was no written guidance available for staff to follow and the plan had not been updated in a two year period. However, incidents of self-injurious behaviour were still occurring on a regular basis. For example from the 5th of December 2024 to the 6th of January 2025 there were five incidents where the resident engaged in self-injurious behaviour, four of these incidents resulted in an injury or re-opening of an existing injury. The inspector was not assured that the measures in place were sufficient in ensuring the residents safety at all time.

In addition, not all staff were up-to-date in refresher training for managing

behaviour that is challenging and de-escalation techniques. Three staff required refresher training in this area. Following the inspection, the provider submitted information that the three staff were booked onto refresher training in April of this year.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that, while safeguarding concerns were being identified, reported to relevant authorities and managed in the centre. Aspects of ensuring controls were in place to safeguard residents from financial abuse were not robust or comprehensive for all residents that lived in the centre.

As part of the inspection process the inspector reviewed the systems in place to safeguard residents' finances. For two out of three residents' finances reviewed it was found that there were robust systems in place to effectively maintain oversight and safeguard their monies. This included residents having a bank account in their own name, regular checks of bank statements against everyday expenditure and audits and reviews of expenditure. However, for one resident these processes and checks were not in place. The provider nor the resident had oversight of their full expenditure. The last statement reviewed by the provider was dated October 2023. Although the provider was aware of this issue there was a lack of progress with meaningful action to date.

In addition, there was no information or system in place to ensure that residents were supported to develop the knowledge, self-awareness and understanding for self- care and protection. There were no easy-read documentation available and this information was not communicated to residents during key-working sessions or resident meetings.

Judgment: Not compliant

Regulation 9: Residents' rights

Overall, the inspector was not assured that a right's based approach to care and support was in place in the designated centre.

Recently, the provider had identified that residents in the centre were not paying the correct Residential Support Services Maintenance and Accommodation (RSSMACs) charges. Although the provider had drafted letters and other information to be communicated to residents and their representatives, this information had not been communicated in a timely manner in this designated centre. The change in resident

charges/fee's was implemented on the 1st January 2025. At the time of inspection, there was no evidence that residents had been consulted with in this process and family representatives had only been made aware of the changes a few days prior to the inspection. This was not good practice in ensuring residents were consulted/communicated with and gave their consent to the recent change in resident charges/fee's.

In addition, on the walk around of the premises, the inspector noted that one resident's bedroom window was facing a residential footpath and the designated centre's car park. Although there were some measures in place such as a blind and curtains (which were open), the resident's right to privacy in this area was not always in place. People walking past this area were able to directly see into the resident's room. This required consideration to ensure the resident's right ot privacy was respected at all times.

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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Renua OSV-0003500

Inspection ID: MON-0045614

Date of inspection: 20/02/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: There were training gaps identified during the inspection for safe administration of medication training. All team members that had outstanding medication assessments have completed same on 11.03.2025 to ensure full compliance with policy. The training matrix for Renua is being reviewed on a monthly basis by the PIC going forward to ensure each team members training is in date. This will be discussed at team meetings and addressed in individual Quality Conversations. Training department highlights the training that is due to expire within 1 month. Training department has also requested that each PIC has assigned a delegated person in the designated centre to support PIC and team in overseeing completion of training. This delegated person has been identified on 12.03.2025 for designated centre Renua. A meeting is also planned to be scheduled in April 2025 with all training delegated persons across the service, training department and Director of Strategic Development to explain the delegated duty and importance of completion of training. A Quality conversations schedule is in place in Renua for 2025, printed and located in the Quality Conversation folder. Each staff member has been scheduled for Quality Conversation as per Aurora policy, same have commenced and Quality Conversations for quarter 1/2025 are now completed.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To address the identified issues in relation to Governance & Management, the following	

actions have been taken so far and/or are planned:

Access to advocacy services has been discussed as part of Focus on Future Meeting with people supported in Renua on 16.03.2025.

Advocacy referral has been sent for person supported who requires advocacy services in relation to support with financial matters on 10.03.2025 by Aurora Social Worker. Person supported is awaiting response from Advocacy services for meeting.

Risk and incident management on provider level has been on the agenda for H&S, DOS and WCI managers and PIC governance meeting over the past few months to address issues in relation to responding and reviewing of incidents and wider risk management.

Incident and accident committee are now involving BSS and WCI managers in reviewing incidents. WCI team has incident review and actions on monthly team meeting agenda.

Based on most recent meeting of the incident accident committee on 04.02.2025. further actions have been agreed between H & S and WCI team to progress incident oversight and management.
1. An emergency teams meeting was held on the 11.02.2025. with all PICs and TLs in relation to reporting incidents on NIMS and review of same, necessary actions to take.
2. A review of PIC monthly status report and QC minute templates has been implemented with DOS and H & S to ensure more detail of incidents are discussed as part of governance and management.
3. A risk management policy review has commenced and the meeting took place on 11.03.2025. DOS and team are currently drafting a fully reviewed policy to also include more detail on provider oversight of risk management and more detailed pathway for PICs in adherence to risk management and relevant systems. The next draft policy is for review on 31.3.25. and will be proposed to CEO for sign off.
4. Incident reviews completed as part of monthly PIC reports and QCs.

Governance actions related to Renua:

1. Meeting held as part of urgent review of findings of inspection between DOS, WCIM and PIC on 20.02.2025.
2. Team meeting took place on 28.2.25 with attendance of WCI managers to discuss action plan and immediate actions with PIC and Renua team.
3. Urgent action plan discussed and implemented between WCI and PIC. A phased review plan developed between WCI and PIC to ensure a full review of service delivery in Renua over the coming 6 months.
4. Communication to families by DOS in relation to HIQA inspection and findings was completed on 20.2.25 and 21.2.25.
5. QC schedule implemented by PIC and quality check by WCIM to be completed as part of regular Quality Conversations. WCIM supported PIC in completion of same.
6. Oversight of implementation of action plan is monitored on weekly basis by WCIM and is evident on Topic Specific Quality Conversations between WCIM and PIC.
7. Incident review and review of risk assessments to be on standing agenda for QC between PIC and WCIM, using examples for review and cross check. On the job mentoring with PIC delivered by WCIM on 28.02.2025.

Since 2024 Aurora has an established audit schedule in place for completion of 6 monthly audits and annual audits as per Regulation 23. There is an additional 1 pager guidance document in place for everyone in the service to ensure employees and managers are aware of audit requirements additional to provider audits on house level. This 1 pager document was re-circulated on 05.03.2025. As part of the local audits, the PIC must complete finance audits on a monthly basis.

Review of an audit folder was completed and updated index added on 25.03.2025. Aurora checklist and audit schedule 2025 is available in the folder- this outlines clear pathway on mandatory checklists and audits to be completed on daily, weekly, monthly, quarterly, 6 monthly and annual basis. Aurora checklist and audit schedule 2025 will be discussed at team meeting on 31.03.2025.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:

Communication assessment in relation to how people supported communicate pain and discomfort (DIS DAT) had been completed 26.03.2025 by PIC and Community Liaison Nurse and Medication Manager.

2 gentlemen have communication dictionaries developed with support of Speech and Language Therapist and 1 gentleman will have communication passport developed by 30.04.2025.

"My Profile" for all gentlemen were reviewed and updated by 25.03.2025 to include clear evidence of their ways of communicating and what is important to them and for them. SLT and OT reports are cross referenced to ensure transfer of communication styles and methods is prescriptive on the profile for each gentleman. Human Rights & Equality Lead supported with this review and update.

Team meeting with Renua team took place on 28.2.25 to discuss findings from inspections and action plan with the PIC and team. In this meeting the above documents were discussed and explained in relation to supporting the gentlemen with their communication style. Discussion was held around the ways of working to support each gentleman on a daily basis and evidence the communication held via Focus on Future planning, evidence on weekly planners, daily notes, etc.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Deep clean of the designated center commenced on 21.03.2025 and completed by 28.02.2025.
Three visits by the IPC Link Practitioner completed to Renua on following dates: 26.02.2025, 12.03.2025 and 19.03.2025 to complete an unannounced IPC audit as requested by WCIM on 26.02.2025. Action Plan identified and plan is in place to address same.

An action plan was developed to address following findings in report:
• Kitchen cupboard doors had peeling laminate - addressed on 06.03.2025.
• The kick boards in the kitchen were marked - all kick boards across the house were painted on 10.03.2025.
• There were gaps in the kitchen flooring were an accumulation of dirt and debris was present as they could not be reached for effective cleaning. The kickboard was replaced and sealed between the kitchen unit and the floor 25.03.2025.
• There was some mold present on the ceiling of the bathroom- cleaned & treated on 06.03.2025. vent fan in the bathroom to be left on when light is turned on while using bathroom. Email sent to all employees in Renua 25.03.2025 to ensure that they are aware of the vent fan. Check for mold has been added to 24-hour cleaning schedule on 27.03.2025 to ensure daily oversights and early identification of same.
• Some paint work in the home was badly marked with grease and there was some chipped paint in places - painting across different areas in house completed on 10.03.2025.
• There were sinks present in bedrooms there were not in use and used for storage of clothes or other items. Some of the tiling around these areas was in poor condition – Sinks are now in use and hand towel holders and soaps are in place. Review of tiling was completed on 25.03.2025 by H&S and their report said that there is no requirement for any further actions.
• Steel shed ordered for Renua 21.03.2025, approx. 6-8 weeks delivery time.
• During visit on the 26.02.2025 OJM provided to PIC & two Renua employees around IPC, OJM form submitted to the Training officer.
• OJM scheduled for the 27.03.2025/03.04.2025/10.04.2025/17.04.2025 around IPC. Aim to provide a refresher around IPC for all Renua employees
• SOP develop re: Laundry Management and Environmental cleaning and issued to team for familiarization and signatures
• Under bed storage researched and purchased for continence wear storage. This is now in place since 26.03.2025.
• H&E currently sourcing quotes for a new fitted kitchen, build quotes into maintenance budget and aim to replace kitchen Q1/2026.

PIC ensures daily oversight of daily cleaning and compliance with IPC via 24 hours cleaning schedule across the center on daily basis. Provider has scheduled 6 monthly audit and annual review for 2025 and IPC Regulation will be audited as part of same.

Regulation 26: Risk management procedures	Not Compliant

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

Risk assessment in relation to outlined incident has been reviewed and updated accordingly on 26.02.2025 by WCIM and PIC. In order to identify the frequency and any potential of the behaviors, Behaviour Support Specialist suggested implementing a scatterplot. Behaviors Support Plan has been developed by Behaviors support specialist on 10.03.2025. Plan is giving a clear guidance to staff on proactive and active strategies. Risk assessment was also developed on 24.02.2025 to support staff and person

supported.

Review of designated center and people supported risk register is scheduled with Quality Department and WCIM and action plan was developed on 18.03.2025.

Incidents are reported via PIC Monthly Status Report that is shared with WCIM on monthly basis and discussed at QC between PIC and WCIM.

Incident and Accident Committee meets monthly and is a new initiative in the service. The committee`s scope incorporates all incidents and accidents occurring within the service involving persons supported, employees, contractors, visitors, or any other individuals directly or indirectly associated with the organization.

Risk assessment associated with restrictive practice of the chain that is in place across an emergency exit was completed on 27.03.2025 with support of WCIM and H&S Department.
The review of restrictive practices and risk assessments linked to same in designated center has commenced with Human Rights and Equality Lead and PIC on 13.03.2025.
Restrictive practices committee is scheduled for 10.06.2025 to review restrictive practices for designated center and gentlemen in full.
Fire Drill has been completed on 27.03.2025 with support of Night Manager to ensure fire safety in circumstance where restrictive practice (chain on emergency exit) is in place.
Initial Teams meeting with PIC and Health & Safety officer took place on the 19.03.2025 around fire drill/evacuation support in Renua. During meeting a comprehensive list of scenarios were identified for the three people supported in Renua.
A schedule for fire drills & scenarios was developed for 2025.
Three dates arranged in Renua for Health & Safety officer to attend to Renua to observe a fire drill and provide OJM around fire safety.
Email sent to PIC and Staff in Renua on the 20.03.2025 with details of the above.
Email sent to Chief Fire Office of Co. Kilkenny to arrange a visit to Renua with the local fire fighters to become familiar with the premises and the needs of the people supported living in Renua. Awaiting confirmation of date.

Risk assessment for fluid thickener has been developed by WCIM and PIC on 28.02.2025.
Wound gel has been now stored in the medical press in line with Medication Management Policy.

Provider has commenced a full review of risk management policy and reporting. This is a cross-function project, which has commenced in November/December 2024; based on challenges identified on completion of NMS reports and reviews. WCI managers, H&S, HR&E Lead and Behaviour Support Specialist involved.
NIMS and risk management was discussed at Governance meeting in February and also at QA meeting on 20.2.25 with clear action plan for all PICs and TLs in relation to incident management on NIMS.
PIC attended Incident/Accident Committee on the 04.03.2025.
PIC scheduled to attend NIMS training on the 30.04.2025.

PIC monthly status report and QC templates between WCI managers and PICs have

been updated to reflect more detail in incident management.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

Behaviors Support Plan has been developed by Behaviors support specialist on 10.03.2025. Plan is giving a clear guidance to staff on proactive and active strategies. Risk assessment was also developed on 24.02.2025 to support employees and person supported.

Refresher training for managing behavior that is challenging and de-escalation techniques is scheduled for all 3 staff on 16.04.2025.

3 employees have completed introduction to positive behavior. All team members will complete introduction to positive behavior by 30.04.2025.

Regulation 8: Protection	Not Compliant

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

Statement of person supported bank account has been received on 25.02.2025 and discussed as part of annual visioning meeting on 28.02.2025. Since the inspection, referral to advocacy services has been submitted on 11.03.2025 to support person supported with their finances.

As a result of further family conversations for a gentleman in relation to his finances, advocacy referral has been completed and further family meetings were held to focus on a solution in relation to financial oversight for this person.
Director of Finances has offered to meet with family and explore next steps of moving finances from shared family account. Family have agreed to meet 28.03.2025.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

In relation to changes of RSMCC charges, the provider has sent hard copy letters in December 2024 to all people supported who had a change to their charges commencing in January 2025. DOS followed up with managers on 16.12.24 via email to highlight this communication. Since the inspection took place on 19.2.25 DOS has requested copies of the letters from Finance Department to be resent to all 3 gentlemen in Renua. PIC ensured the letters are communicated with the Easy Read document provided by DOS via email. Evidence of this communication is available on daily notes and the Easy Read and letter are signed by PIC. Letters are filed in each person supported file as requested with the Provision of Service Document.

In relation to a person supported's dignity and respect in ensuite bathroom and

bedroom, window protection has been applied to their window on 25.03.2025 which allows person supported to look out but ensures that their dignity and privacy are protected.

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.	Substantially Compliant	Yellow	28/03/2025
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	11/03/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/03/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	28/03/2025

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	28/02/2025
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	31/03/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/04/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to	Substantially Compliant	Yellow	16/04/2025

	behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	10/03/2025
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	11/03/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/03/2025
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where	Not Compliant	Orange	28/02/2025

	necessary, to decisions about his or her care and support.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	25/03/2025