Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	L'Arche Ireland - Kilkenny (An Solas/Chalets)
Name of provider:	L'Arche Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	10 February 2025
Centre ID:	OSV-0003419
Fieldwork ID:	MON-0045217

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 10 February 2025	08:00hrs to 14:00hrs	Linda Dowling	Lead
Monday 10 February 2025	08:00hrs to 14:00hrs	Conor Brady	Support

What residents told us and what inspectors observed

This was a short noticed announced inspection carried out with a specific focus on safeguarding, to ensure residents felt safe in the centre they were living in and they were empowered to make decisions on their care and how they wished to spend their time. The inspection was carried out by two inspectors over one day.

Overall, the inspection found that residents were in receipt of good care and support and found positive examples of how residents were supported to make decisions. However, there were some areas that required improvements such as premises, maintaining residents privacy and personal planning, these will be discussed in more detail later in the report.

This centre comprised of one main house with a self contained apartment attached to the rear of the house and four chalets to the front of the main house all on the same grounds. Ample parking was available to the front of the house and an area set to lawn to the rear. There were four residents living in the main house, one resident had just moved into the apartment from a chalet the week previous. One chalet was vacant and one was occupied, with the remaining two being utilised by the day service as their building was undergoing renovation works. The inspectors were informed the renovations had started in early January and were due to be completed by the end of the month.

On arrival to the centre, the inspectors were greeted at the door by a resident who checked their identification and welcomed the inspectors into the house. The centre was found to be clean and warm with residents having breakfast and getting ready to go to their individualised day programmes and activities. One resident had the support of one-to-one staffing and was due to go into the city for a walk and meal out. Other residents were due to go day service some attending the one operated by the same provider and one resident attended a day service from another provider.

The inspectors met with the residents, members of the employed staff team, live in assistants, the person in charge, service manager, safeguarding officer and interim CEO. From these discussions, observations on the day of the inspection and review of documentation, residents were supported in line with their assessed needs and given opportunities to be part of the overall decision making of the centre.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, it was found that there was robust management systems in place to ensure that the service provided was safe and in line with the assessed needs of the residents. There was a regular management presence in the centre, with a full-time person in charge and team leader in place. The provider had established good systems to support the provision of care and support to the residents.

There was a consistent staff team in place with very little need for agency staffing. The number and skill mix of staff were appropriate to meet the needs of the residents and in line with the current safeguarding plan and statement of purpose.

Regulation 15: Staffing

Staffing in the centre consisted of two staff on duty each day and one waking staff at night. There was also four live-in assistants that supported the residents on a volunteer basis. Staff were observed to be respectful when to talking to and about residents. The staff team were all familiar with the support needs of each resident and were observed to interact with residents supporting them to make decisions throughout the day. The provider had increased the level of staffing within the centre over recent months. Thee centre was now staffed on a 24 hour basis across seven days of the week. This had lead to improved lived experience for the residents living in the centre.

The inspectors reviewed all staff and live-in assistant personnel files and found that for the most part they contained all the necessary information such as identification, references and Garda vetting. Garda vetting for one live-assistant was due to completed again over this month. The provider gave assurances to the inspectors that this would be completed in the coming days.

From speaking with members of the staff team they reported they felt supported in their roles and were happy working in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix for all staff and live-in assistants in the

designated centre. It was found that all staff were provided with the required training to ensure they had the necessary skills to respond to the needs of the residents and to promote their safety and well being. All staff had up-to-date mandatory training such as fire safety, medication management, people and moving handling.

The person in charge completed the team leaders supervision meetings and the team leader had responsibility for completing regular support and supervision meeting with the rest of the staff team. The inspectors reviewed the support and supervision meetings for the team and found they were planned in advance with agenda items from the supervisor and staff member brought forward to the meeting. Topics discussed included training, safeguarding and supports for residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place which was lead by the person in charge who also had responsibility for two other designated centres operated by the same provider. The person in charge reported to the service manager.The person in charge was supported in their role by a team leader and deputy team leader, who both were actively involved in the centre. All of the local management team completed managerial tasks and supported the residents on a day-to-day basis. Overall, the management of the centre was effective. The provider's systems were implemented and utilised effectively by members of the management team.

From speaking with the team leader who was present on the day of the inspection, they were knowledgeable of the residents' care and support needs. For example, the inspector requested further information on a health concern in relation to one of the residents. The team leader was able to inform the inspector of the follow up that had taken place in relation to this concern and showed documentation to support this. This indicated that the team leader had oversight and knowledge of the ongoing care needs of the residents.

A management meeting took place weekly involving the person in charge, service manager, team leader and day service co-ordinator. This meeting gave an update on residents' well being and any concerns or incidents. House meetings were also taking place weekly with the staff team. The inspectors reviewed the minutes of these meetings and found they were very detailed. For example, from the minutes reviewed the following was discussed at the meeting; updates form management, resident needs, resident plans and resident specific requests, risk assessments, safeguarding plans and incidents. This ensured that effective communication between staff and management was occurring on a regular basis.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the quality and safety of care provided for residents, was of a good standard. The inspectors noted residents had opportunities to take part in activities and to be involved in their local community. Residents were making decisions about how they wished to spend their time and were supported in developing and maintaining connections with their families and friends. Some areas of care and support required improvement, such as premises condition, ensuring residents' goals were in place and ensuring residents' right to privacy was respected at all times.

The premises, while in need of some repairs, was spacious and suitable for the needs of the residents living there. The staff and management team were striving to provide a person-centered care to the residents, enabling them to express their views and make decisions about their care and support needs.

Safeguarding concerns were being identified and reported to the relevant authorities and managed well within the centre currently.

Regulation 10: Communication

Residents' communication needs were outlined in their personal plans and throughout their individual support plans. Staff were familiar with their communication requirements and this was observed by the inspector on the day of inspection. For example, one resident responded best to simple and straightforward language. The inspector saw staff use this style of communication with the resident.

The residents 'my life my plan' document has a section dedicated to how I communicate, it included guidance for staff on the preferred form of communication for the individual. It also included any known other forms of communication such as body language and how the resident might present if they are feeling anxious or upset. From observation of interactions between staff and residents, all staff were familiar with the residents' communication attempts and were seen to respond appropriately to residents requests.

The inspector reviewed residents' meetings since the start of the year and it was clear this form was being used to allow residents communicate and record their needs and wishes on a weekly basis.

Judgment: Compliant

Regulation 13: General welfare and development

The provider and staff team had ensured that a variety of activities were available for residents, both in their homes and in the local community. Staff recorded planned activities and noted whether they had been enjoyed by the resident. Outings included shopping, dining out, massage and visiting friends and family. Residents also took part in in-house activities including baking, watching movies, music and art.

Residents were attending individual day service programmes where they had opportunities to meet their friends and part take in activities such as art and craft, working on a local news letter or cooking.

Judgment: Compliant

Regulation 17: Premises

As mentioned earlier this centre comprises a main house with an attached self contained apartment, and four chalets to the front of the main house. The inspectors completed a walk around of the main house, apartment and chalets, and for the most part it was clean and well maintained. However, on review of the kitchen the inspectors saw peeling laminate present on the kitchen cupboard doors. There was mold present on the bathroom ceiling that needed to be addressed.

On arrival into the main house it felt warm and homely, residents were getting ready to start the day and were having breakfast in a large open plan kitchen and dinning area. Each resident had their own bedroom which was decorated to their individual style and preference and had adequate storage for their belongings. One resident who was recently supported to move from one of the chalets to the apartment at the main house picked out paint colours for the apartment to be painted before they moved in. They also decided to move some furniture around in their room as they had a preference for their bed to be at the wall. This resident proudly showed the inspectors their apartment.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place to identify, manage and review risks in the centre with a focus on residents' safety.

The inspectors reviewed the residents' individual risk assessments and found the provider was identifying and managing risk appropriately. The provider had risk assessments in place that were up to date and were subject to regular review by the person in charge. The risk assessments clearly identified the risk and the control measures that were in place and any change to these controls were noted in the review section.

The inspector reviewed all formal safeguarding plans in place and these plans were reflected in associated risk assessments. Risk assessments were also developed to reflect any restrictive practices that were currently in place within the centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had policies, procedures and systems in place for the receipt, storage, return and administration of medications. The inspectors observed that there were suitable storage facilities for medicines, including a system for storing additional stock.

Good practice measures were in place for the administration of medication. For example, the inspector observed one resident receiving their morning medication with the support of staff. The resident informed the inspector they had diabetes and needed to get their blood sugar levels tested daily. The staff member supported the resident to have this completed. The inspector found the staff to be respectful and they completed the task in a professional manner, The staff member also followed good practice guidance such as completing hand washing before the administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed three residents' personal plans and found them to be clearly laid out and contained good guidance. The residents personal plans were reviewed yearly with the relevant people involved in their lives present for the meeting including a member of staff from their respective day programme.

From review of the plans in place each resident had their support needs identified and a support plan in place outlining how these needs were met. Examples of support plans included, health care and medication, communication, traveling alone, and social media. Each resident had a document titled 'my life my plan', this document gave an overview of the resident and ensured staff were aware of the

residents' likes and dislikes and that was important to them.

While each resident had goal recorded as part of their annual review some goals, were of poor quality and required review. For example, the resident that had recently moved from a chalet into the apartment had no associated goal with this significant life event. In addition, although some residents had appropriate goals set in 2023 and 2024 such as attending course on decision making, joining regional advocacy committee meetings, working with horses or fashion, there was limited evidence available to indicate if these goals had been achieved or were in progress. The documentation process in relation to residents' goals required improvement to ensure progress was captured in an effective manner.

Judgment: Substantially compliant

Regulation 6: Health care

Each resident's health care supports had been appropriately identified and assessed. The inspectors reviewed healthcare plans and found that they effectively guided the staff team in supporting residents with their health care needs. The person in charge ensured that residents were facilitated in accessing appropriate health and social care professionals as required. While some residents found appointments difficult they were supported by familiar staff and desensitisation programmes were in place to ensure appointments were successful. One resident was awaiting an appointment in relation to a health concern, this was been managed with appropriate follow up.

Each resident had a medical overview plan in their file that outlined all their appointments and medical procedures. For example, on one plan reviewed the inspectors saw that bloods tests and vaccination programs were recorded for 2024 and 2025.

Judgment: Compliant

Regulation 8: Protection

The inspection found that safeguarding concerns were being identified, reported to the relevant authorities and managed with appropriate control measures in place within the centre. For example, as a result of a safeguarding incident one resident is now supported to get a taxi with staff to their day programme instead of using public transport. This ensure that the resident is kept safe at all times and relevant risks are managed appropriately.

The safeguarding plans were subject to ongoing review. The plans offered guidance for staff and the guidance was consistent across all documentation such as

safeguarding plans, risk assessments and personal plans. There was a record of ongoing discussions at supervision and team meetings on the topic of safeguarding. All staff had received training in safeguarding of residents, and were aware of the various types of abuse, the signs of abuse that might alert them to any issues, and their role in reporting and responding to those concerns.

At the weekly residents meetings, each resident had the opportunity to speak and raise any concerns they might have, they also discussed events, activities, goals, and menu planning, the minutes were signed off by residents each week.

Residents were also supported to raise complaints in relation to external services or facilities. For example, one resident was supported to make a complaint in relation to inappropriate wording recorded in their hospital file. The resident received an apology from the hospital and the wording was removed from the file.

Judgment: Compliant

Regulation 9: Residents' rights

From review of documentation, discussion with staff members on duty, management, the safeguarding officer and from the inspectors observations, residents were supported to exercise their rights. Residents were provided with relevant information in a manner that was accessible to them and given time to make a decision. They were supported to make choices about how they wished to spend their day.

However, on the day of the inspection inspectors observed a large number of people including, day service staff, residents, builders and a visitor walk at down a path at the rear of the main house and chalets. While walking down this path you had a direct view into aspects of the residents' home and bedrooms. The inspectors were informed there was a significant increase in the amount of people using this path currently as there was building works in the day service which was located at the end of the path and the day service was currently operating out of one of the vacant chalets. As a result of this there was a lack of privacy afforded to the residents of this centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

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

Inspection ID: MON-0045217

Date of inspection: 10/02/2025

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Bathroom repairs have been assessed by builder and this work will be completed by 30th April 2025. • Kitchen cupboards will be repaired in the interim while waiting for costings for new kitchen. 30th April 2025	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Residents goals will be reviewed regularly. All actions, updates and who is responsible to ensure these are happening will be documented. 30th March 2025	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The Day Service Programmes will move back to the Day Project Building on 11th March 2025, and this will extensively cut down on the foot fall to An Solas/Chalets.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/04/2025
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/03/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in	Substantially Compliant	Yellow	11/03/2025

	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.			