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:	Rose Lodge
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	17 February 2025
Centre ID:	OSV-0008576
Fieldwork ID:	MON-0046374

About the designated centre

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

Rose Lodge is a designated centre which can provide full-time residential services for up to four male or female adult residents. It is situated on the outskirts of a large town in Co. Kildare. There are a number of vehicles available in the centre to support residents to visit their family and friends and to access their local community. Rose Lodge can provide a high support service for adults with Prader-Willi Syndrome who may present with complex needs. The house is sub divided into four self-contained apartments and there are a number of communal areas such as a living room, sun room, kitchen, utility room, and office. Residents' apartments have a living room, kitchenette, bedroom and bathroom. There is a driveway at the front of the house and a garden to the back. Residents are supported 24/7 by a staff team consisting of a person in charge, service manager, and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 17 February 2025	09:00hrs to 13:30hrs	Sarah Cronin	Lead
Monday 17 February 2025	09:00hrs to 13:30hrs	Tanya Brady	Support

What residents told us and what inspectors observed

From what residents told us and what inspectors observed, it was evident that residents living in the centre were supported to access a range of activities in line with their interests. For some residents living in the centre, their lived experience had improved since the last inspection, while for another, their experiences in the centre remained challenging for their safety and well being. The inspection found poor levels of compliance with regulations which were inspected. Improvements were required in governance and management, risk management and staff training and development. These are discussed in the body of the report below.

The designated centre provides a specialised residential service to four young adults who have a diagnosis of Prader-Willi Syndrome (PWS). The house is subdivided into four apartments, each containing a sitting room, bedroom and bathroom. There is a communal dining room and sitting room. The kitchen of the house is locked in line with best practice guidelines for PWS, and accessed directly through the kitchen door, or via a coded back door. The areas which the inspectors viewed within the house were in a good state of repair. However, there were external areas that required review to ensure that the residents had a safe and welcoming garden available to them. The provider addressed these on the day of the inspection.

There were four residents living in the house on the day of the inspection. Inspectors met with the regional operations manager and the director of services in addition to a number of members of the staff team. On arrival, one of the residents was in bed and reported to be feeling unwell. Another resident had gone out with staff and another was due to return from a weekend away with their family. An inspector had an opportunity to meet with one resident in their apartment. The resident told the inspector that they were happy in their house and spoke about activities which they enjoyed doing with staff such as going to a local gym, going swimming and attending a community centre. There were photographs displayed in their apartment of family members and them enjoying activities.

Staff members showed inspectors residents' daily planners which were varied and busy. Activities included things such as going to a library, visiting coffee shops, going shopping, going to the gym and going to a petting farm. Within the house, residents had access to their own electronic tablets, television and art supplies. Staff were observed over the morning completing household tasks and ensuring that the environment was clean and comfortable for residents.

There had been a number of peer-to-peer incidents occurring in the centre which was impacting upon resident's rights and quality of life in the centre. The provider had reduced the risk of these incidents by ensuring that one resident did not access the communal areas, and received support in their apartment. While this had significantly improved three of the residents' experiences, for one resident it was evident that they were unhappy with some aspects of their new living arrangements, and that there had been incidents of concern occurring which

compromised their safety.

The next two sections of the report present the findings in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of care and support in the centre.

Capacity and capability

This was an unannounced risk-based inspection, which took place following receipt of solicited and unsolicited information of concern. A number of pieces of solicited information which related to safeguarding had been submitted to the Chief Inspector via the notifications process, in 2024. The provider was required to submit a Provider Assurance Report to the Office of the Chief Inspector in November 2024. This gave assurances on the measures which the provider was taking to manage peer-to-peer safeguarding in the centre. Inspectors found that the provider had implemented the actions which they had committed to, and this had resulted in a reduction in peer-to-peer incidents in the centre. Unsolicited information received related to safeguarding and governance and management arrangements in the centre.

The inspection was completed in a shortened time frame due to information of concern emerging over the course of the day which the provider required further time to review. It is acknowledged that this report is reflective of a small number of regulations which were inspected against in this reduced time frame, and that there were areas of good practice in the centre to ensure residents enjoyed a good quality of life.

Inspectors found that the governance and management arrangements in the centre were ineffective in ensuring that service delivery was safe for residents. There had been an inconsistent management and staff team over the last 18 months. This had included three persons in charge and two team leaders in addition to changes in the staff team. As a result, inspectors found gaps in the monitoring of areas such as finances, medication, staff supervision, safeguarding and incident review. These areas are further discussed under Regulations 16: Training and Staff Development and Regulation 23: Governance and Management below.

Regulation 16: Training and staff development

The inspectors reviewed the staff supervision and support systems in place for staff and found that these had not been consistently implemented in line with the provider's policy. This was a repeated finding from three previous inspections of this centre.

Inspectors were not presented with evidence to demonstrate that mentoring was provided on-the-job or that oversight of staff practice was consistently in place. For example, inspectors saw evidence in incident reports that staff had not responded to residents' requests, or incidents were residents were left unsupported in spite of asking for company. There was no evidence of follow up from these incidents, and issues were repeated. Inspectors did not see evidence of staff supervision or staff meetings to show that guidance was provided for future learning.

Judgment: Not compliant

Regulation 23: Governance and management

The provider's oversight arrangements had not consistently identified and managed risk and safety concerns in line with their policies and systems. As outlined earlier, there had been a number of changes to the management team in the centre since it had opened in 2023. There had been three persons in charge and two team leaders in this period. A new person in charge had commenced in their role in January 2025, and left within a number of weeks. On the day of inspection there was no person in charge in the centre and the person participating in management had been identified as an interim arrangement. However, the member of management also had responsibility for other services within the organisation and this large remit would require monitoring to ensure regulatory responsibilities could be met in the centre. The provider gave inspectors an assurance that a member of management would be in the centre five days a week, and this arrangement had commenced on the day of the inspection.

Due to the lack of consistent management presence in the centre, inspectors found that the provider's systems to monitor and oversee the service were not being utilised effectively. This was evident across a number of areas including risk management, the management of finances, safeguarding and medication management. Inspectors observed poor communication within the staff team and from management to staff. For example, inspectors viewed the electronic tablet which staff used for information, and this was not seen to be fully updated. Staff who spoke with inspectors stated that they were not always clear on who was present for them to speak to and they did not know what was going on in the centre. A member of the provider's senior management team was present in the centre on the day of inspection to review processes and guidance in place and to meet with members of the staff.

While the inspectors acknowledge that the provider was aware of some of the issues identified on this inspection, their systems had not been consistently implemented which resulted in other issues not being identified or actioned. For example a financial discrepancy of a considerable sum of money was clearly identified on a centre checklist however, as these had not been audited or verified in person, the required safeguarding and investigation response had not taken place. There had been a delay in staff reporting some incidents, while in other cases, it was not

evident that incidents were reviewed to ensure that learning and actions were implemented promptly. This was also found on previous inspections, and is further discussed under Regulation 26: Risk management procedures.

The provider's annual review had only identified actions required in two areas and while family input was sought the two family questionnaires reviewed were unsigned and undated. These family questionnaires contained concerns regarding staffing changes in the centre and it was not clear whether these concerns had been followed up on.

Judgment: Not compliant

Quality and safety

Inspectors found that residents were supported to engage in activities of their choosing, and to maintain close family relationships. They had access to a range of health and social care professionals which included a GP, a behaviour specialist, a dietitian and a psychiatrist. As outlined previously, there had been a trend of safeguarding notifications in the centre. The provider had addressed this by putting a restrictive measure in place for a resident. This had reduced peer-to-peer incidents. However, this new arrangement had presented different risks to the resident which required review to ensure that they remained safe, and that they enjoyed a good quality service in their home.

Inspectors found that there were ineffective monitoring and oversight arrangements in place to manage risk in the centre. There was poor practice in reporting, in reviewing, and in implementing required actions to mitigate against risk in the centre. This had a negative impact on residents and staff working in the centre and resulted in staff injuries, and risks to a resident.

Regulation 26: Risk management procedures

Inspectors found that while the provider had a robust system in place to oversee risk and manage adverse incidents, these systems were not being utilised effectively in this centre. This meant that prompt and effective sharing of recommendations or learning from the management and review of adverse events and incidents was not occurring.

Inspectors reviewed a sample of 20 incidents which had occurred in the centre since the last inspection in July 2024. A number of these related to one resident who had been involved in incidents which presented a high level of risk of injury to themselves and to staff. However, inspectors did not see documentary evidence of follow up by management for these incidents. For example, two incidents had

occurred within a short time frame where a resident had left their apartment unaccompanied. These incidents were not reviewed and learning was not identified or implemented, leading to a repeated pattern of the resident leaving their living area unaccompanied which placed them at risk. While the interim person in charge reported reviewing these incidents, there was no documentary evidence to demonstrate this.

A number of incident reports did not provide sufficient detail for the provider to ensure that staff had adhered to residents' care plans, particularly their behaviour support plans. This had been found on previous inspections as an area of concern. For example, one incident referenced staff holding a resident. However, holds had been discontinued in the resident's behaviour support plan in April 2024. It was unclear what hold was used, and for how long to ensure that the least restrictive option had been used for the shortest possible time.

Decision-making in relation to managing risk following removal of a restrictive practice required review. For example, one restrictive practice on transport had been removed without clear consideration of the increased risk which this presented. Following this removal, there had been two serious incidents on the bus. Again, it was unclear what follow up actions were taken to mitigate against this high risk.

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 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant

Compliance Plan for Rose Lodge OSV-0008576

Inspection ID: MON-0046374

Date of inspection: 17/02/2025

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	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

The provider acknowledges the findings regarding staff supervision, mentoring, and oversight of practice, and we recognise the importance of ensuring that these processes are consistently implemented in line with our policies and HIQA regulations on disability services.

To address these concerns, we have taken the following actions:

• Staff supervisions have commenced and will now be conducted regularly in line with policy. These sessions will address both individual concerns and broader themes within Rose Lodge that require further discussion and development.

• Management maintains a presence in Rose Lodge five days a week, providing consistent on-the-floor mentoring and support for the staff team.

• The service has successfully recruited a Team Leader for the service who is due to commence employment in April 2025 this will further enhance staff supervision and support.

• All incidents involving resident requests and support needs will be reviewed in a timely manner. Staff are required to document follow-up actions, and management oversight will ensure that learning from these incidents is applied consistently.

• Learning outcomes from all incidents will be shared with staff during monthly team meetings to promote ongoing learning and continuous improvement.

• A comprehensive review of the training matrix is underway, with all outstanding training requirements identified. Staff are actively working through these courses to ensure full compliance.

• A full review of all resident documentation is in progress to ensure the team has access to the most up-to-date and accurate information, enabling them to provide the highest level of support.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The provider acknowledges the inconsistence in management and governance arrangements in the centre mainly attributed to the change in a number of key personnel since the registration of the centre.

• A management presence is maintained in Rose Lodge five days per week to provide consistency, oversight, and mentorship for the team. This is clearly outlined on the rota to ensure staff are aware of the designated manager each day.

• A new full-time Team Lead will commence in Rose Lodge on 14/04/2025, providing additional stability and day-to-day leadership.

• A designated shift lead is assigned daily on the rota to oversee documentation completion and support the effective running of each shift, ensuring staff have clear guidance and leadership at all times.

• Specific auditing responsibilities have been assigned among management and staff teams to establish clear guidelines, enhance accountability, and ensure robust governance.

• A comprehensive review of all incidents is underway, with collaboration from the Behaviour Specialist to enhance trend analysis linked to individual risks, improving proactive support strategies.

• A full audit and review of financial processes has been completed by the providers internal finance controller, a report has been prepared with clear recommendations for improvements in financial processes. Staff will receive additional training on the finance policy and related documentation to ensure compliance and best practices in financial oversight.

• A full review of all documentation within Rose Lodge is underway to ensure information is up-to-date and accurate, enabling the team to provide the highest quality support.

• The electronic tablet used for information sharing is being updated regularly to ensure all staff have access to current and relevant information.

• Clear communication structures have been put in place so that staff are always aware of who they can escalate concerns to and receive timely guidance.

• The provider is reviewing previous family questionnaires to ensure all concerns raised are followed up on and appropriately actioned.

• We are reinforcing our systems to ensure that all reported incidents are reviewed in a timely manner, with appropriate follow-up and learning applied across the team.

• Resilience Healthcare talent acquisition team continue to recruit for a Person in Charge.

Regulation 26: Risk management procedures	Not Compliant

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

• A management presence is maintained five days per week to provide leadership, guidance, and oversight, ensuring staff have access to consistent mentorship.
• A new full-time Team Lead will commence in Rose Lodge on 14/04/2025, providing additional day-to-day leadership and stability.
• A designated shift lead is assigned daily to oversee documentation completion and support the effective running of each shift, ensuring staff have clear guidance and leadership at all times.
• Management is actively mentoring and supporting staff during daily operations to reinforce best practices and compliance with policies.
• A comprehensive review of safeguarding risks and individual-specific risks is underway, ensuring proactive risk management tailored to resident needs.
• An assessment of the physical environment is being conducted to identify and address any potential risks, including staff positioning when a resident requests time alone.
• A full review of restrictive practices is in progress to ensure all interventions align with best practices and ethical guidelines.
• Ongoing trend analysis of incidents for identified individuals is being conducted to support data-driven decision-making and risk mitigation.
• The complex case forum has been reopened for one of the individuals at Rose Lodge, facilitating multi-disciplinary discussions and tailored support strategies.
• All incidents are reviewed by management within 72 hours. This includes identifying trends, implementing learning, and ensuring corrective actions are taken.
• All adverse events are analysed, and learning outcomes are shared with the team. Minutes from these meetings will be recorded, and action plans monitored for completion.
• A comprehensive review of all incidents is underway, with collaboration from the Behaviour Specialist to enhance trend analysis linked to individual risks, improving proactive support strategies.
• Detailed learning outcomes from incidents will be shared during team meetings to promote continuous improvement and staff awareness.
• Thematic discussions on risk and safeguarding will be integrated into staff supervisions, reinforcing awareness and accountability.
• A full review of all documentation within Rose Lodge is underway, ensuring up-to-date and accurate information is accessible to the team.
• The electronic tablet used for information sharing is being updated regularly, ensuring all staff have access to current and relevant information.
• Clear auditing responsibilities have been assigned for medication management, financial oversight, documentation, and environmental checks, ensuring consistent monitoring and compliance.
• A new quality control check on incident reports has been introduced, where management will review and verify that reports contain sufficient detail before being signed off.
• The team is actively working towards full compliance with the training matrix, ensuring staff are adequately equipped to meet all regulatory and operational requirements.
• A full review of all Behaviour Support Plans (BSPs) has commenced, ensuring staff have up-to-date information on approved interventions and restrictions.
• All incidents involving physical interventions will be flagged for immediate management review, ensuring compliance with behaviour support plans and regulatory requirements.

• Staff will receive refresher training on positive behaviour support, ensuring all interventions align with individual BSPs and restrictive practices are used only when explicitly approved.
• A risk assessment is in place, ensuring any removal of a restrictive practice is supported by a detailed risk assessment and mitigation plan.
• All incidents related to restrictive practice changes will be reviewed by the Behaviour Specialist and Person in Charge (PIC), ensuring proper oversight before further changes are implemented.
• A full audit and review of financial processes has been completed. Staff will receive additional training on the finance policy and related documentation to ensure compliance and best practices.
• Clear communication structures have been put in place so staff always know who to escalate concerns to and can receive timely guidance.

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	21/03/2025
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	21/03/2025
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and	Not Compliant	Orange	30/04/2025

	professional responsibility for the quality and safety of the services that they are delivering.			
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