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:	Ceol
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:	23 May 2024
Centre ID:	OSV-0007747
Fieldwork ID:	MON-0039399

About the designated centre

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

Ceol is a designated centre operated by Aurora. The designated centre provides a community residential service for up to four adults with a disability. The designated centre is a large purpose built bungalow located in County Kilkenny which comprises of four individual resident bedrooms, shared bathrooms, an open plan living, dining and kitchen area, visitors room and utility room. There is a private garden to the rear of the premises for residents to avail of as they please. The centre is staffed by the person in charge, staff nurse, social care workers and care assistants.

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
Thursday 23 May 2024	09:15hrs to 17:30hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This was an unannounced inspection completed by one inspector in one day. The purpose of the inspection was to monitor the centre's compliance with the regulations and the implementation of the actions which were identified in response to the previous inspection.

This centre was last inspected in September 2022. There had been a change in the local management team and some changes in the resident group due to a bereavement and an admission of one new resident to the centre since that inspection. The previous inspection identified areas for improvement with staffing, governance and management, personal possessions, risk management, infection control and fire safety. While, the current inspection identified that the person in charge and staff team had implemented the compliance plan, this inspection found that there remained areas for improvement.

The designated centre comprises a purpose built bungalow located in County Kilkenny which comprises of four individual resident bedrooms, shared bathrooms, an open plan living, dining and kitchen area, visitors room and utility room. On the day of inspection, the inspector had the opportunity to met all four residents living in the service.

On arrival at the designated centre, a staff member welcomed the inspector. At this time, one resident was listening to music in their bedroom waiting to attend their day service. The second resident was enjoying a cup of tea preparing for the day. A short time later the two residents left the centre to attend day service and work. On the day of inspection, two residents remained at home. The third resident was observed in the morning preparing for the day and spending time with the staff team. A fourth resident was feeling unwell and was resting in their bedroom. Later in the morning, the third resident was supported to access the community and engage in activities in the home. The inspector observed a General Practitioner (G.P.) attending the service to visit the fourth resident.

In the afternoon, the inspector observed the fourth resident briefly spending time in the open plan kitchen, sitting and dining room before returning to their bedroom. In addition, residents were observed enjoying music being played by a staff member. The two residents returned from their day service and appeared happy to be home and spoke about their activities for the day. Overall, residents appeared comfortable in their home and in the presence of the staff team.

The inspector completed a walk around of the designated centre. In general, the house was observed to be well-maintained and decorated in a homely manner. Resident bedrooms were personalised with personal items and pictures of people important in their lives. While there were minor areas of scratched paint in need of attention, this had been self-identified by the provider.

Overall, the residents appeared comfortable in their home and the staff team were observed supporting the residents in an appropriate and caring manner. The inspector found that the provider had responded to the findings of the previous inspection and implemented the compliance plan. However, some areas for improvement remained including staffing, governance and management, the management of resident's personal possessions and fire safety. In addition, staff training and development required improvement.

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

Capacity and capability

The inspector found that the local management and staff team were striving to provide a service that was safe, consistent and appropriate to residents' needs. On the day of the inspection, the inspector observed sufficient staffing levels in place to support the residents. However, improvement was required in the staffing arrangements, training and development and the governance and management systems to ensure a safe and quality service.

The centre was managed by a full-time, suitably qualified and experienced person in charge. There was evidence of local quality assurance audits taking place. These included the annual review and six-monthly provider visits as required by the regulations. However, improvement was required in the monitoring of the service. For example, the provider's annual review of quality care and support did not demonstrate consultation with residents and their representatives as required by the regulations. In addition, some audits were not being completed as per the provider processes. For example, audits of resident's finances.

On the day of inspection, there were appropriate staffing levels in place to meet the assessed needs of residents. Throughout the inspection, staff were observed treating and speaking with residents in a dignified and caring manner. However, the staffing arrangements required review to ensure the planned staffing levels were maintained.

The inspector reviewed a sample of staff training records and found that for the most part all of the staff team had up-to-date training, skills and knowledge to support the needs of the residents. However, three staff members working in the centre required training in de-escalation and intervention techniques.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the designated centre who was suitably experienced. The person in charge was also responsible for two other designated centres.

Judgment: Compliant

Regulation 15: Staffing

The previous inspection found that the staffing arrangements required review to ensure they were appropriate to the needs of all residents and the size and layout of the centre. While, there had been some changes in the resident group living the centre, this remained an area for improvement.

On the day of this unannounced inspection, the registered provider ensured that there were sufficient staffing levels to meet the assessed needs of the residents. For example, in the morning the four residents were supported by two residential staff members. In the afternoon, when residents returned from day services, the four residents were supported by three staff members. At night, one waking-night staff was in place to support the four residents. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner.

The person in charge maintained a planned and actual staffing roster. The inspector reviewed a sample of the roster and found that there was an established staff team in place which ensured continuity of care and support to the residents. However, on review of the planned and actual roster for April and May, the inspector found that improvement was required in the maintenance of the roster as it did not always accurately record the actual staff on duty.

The centre was operating with one whole time equivalent vacancy and two whole time equivalents on approved leave. This was managed through the existing staff team and the use of regular relief and agency staff. The inspector was informed that the provider was actively recruiting to fill the vacancy. There had been also recent improvements in reducing agency use and the provider had recently identified one new staff member to provide regular relief. However, on ten occasions in the two month period the staffing levels fell below the planned staffing complement as the afternoon shift was not covered. While the reduced staffing levels were in line with minimum safe staffing levels for this centre, the staffing arrangements required further review to ensure the planned staffing complement levels were maintained.

Judgment: Not compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. From a review of the centre's training matrix and a sample of the corresponding training certificates, the inspector found that the majority of the staff team had up-to-date mandatory training in areas including safeguarding, fire safety and manual handling. However, three staff members working in the centre required training in de-escalation and intervention techniques. In the afternoon of the inspection, the person in charge noted that this had been scheduled for September 2024.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The person in charge reported to the Service Manager, who in turn reported to the Director of Services. The person in charge was responsible for two other designated centres and was supported in their role by a team leader.

The previous inspection found that improvement was required in the effective monitoring of the service as the annual review and six-monthly provider visits were not carried out in line with the regulations. This had been addressed and there was evidence of the annual review 2023 and six-monthly provider visits taking place in line with the regulations. However, the annual review did not include consultation with residents and their representatives. This had been self-identified by the provider and a new template was in place to capture the consultation.

In addition, some improvement was required to ensure local audits were completed as per the provider processes. For example, audits of resident's finances. This is outlined under Regulation 12: Personal Possessions

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of adverse accidents and incidents occurring in the centre and found that the Chief Inspector of Social Services was notified as required by Regulation 31.

Judgment: Compliant

Quality and safety

Overall, the service provided person centred care and support to the residents in a homely environment. The inspector found that residents were in receipt of a good quality of care and support. However, improvement was required in the management of residents' finances, personal plans and fire safety arrangements.

The inspector reviewed three of the residents' personal files which comprised of an comprehensive assessment of the residents' personal, social and health needs and personal support plans. However, a number of the personal support plans reviewed were found to require review to ensure they were up-to-date and suitably guiding the staff team in supporting the residents with their personal, social and health needs. It was evident on the day of inspection that the staff team were actively in the process of the reviewing personal plans.

The previous inspection found that the systems in place for the management and oversight of residents' finances required review. The inspector found that this had not been appropriately addressed. For example, financial competency assessments had not been completed for a number of residents and local audits had not been completed in line with the provider's policy.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place. However, some improvement was required in the arrangements in place for the safe evacuation of all persons in the event of a fire.

Regulation 12: Personal possessions

The previous inspection found that the systems in place for the management and oversight of residents' finances required review. The inspector found that this had not been appropriately addressed and remained an area for improvement.

The inspector reviewed three residents' financial files and found that financial audits of residents' finances were not completed monthly as per the provider's policy. On review of residents' files, monthly audits had not been recently completed. This was also found on the previous inspection.

There was a clear and detailed system in place for the management of day-to-day spending which included daily checks and storage of receipts. The inspector reviewed two residents' finance ledgers and compared the figures to the actual amounts present in residents' wallets and found that they matched. However, some improvement was required in the day-to-day financial recording. For example, the appropriate recording and storage of receipts.

The provider had previously identified that all residents did not have consistent access to bank accounts which was as a result of the systems in place within the organisation in addition to challenges for residents in engaging with financial institutions. As part of their focused improvements in this area the provider has introduced a debit card system to support more regular access to their money for

residents. Systems of oversight on this card run alongside systems of oversight for accounts and of cash management and other card expenditure.

Judgment: Not compliant

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner and well maintained. The residents' bedrooms were decorated with residents' personal possessions and pictures of people important to them. Resident artworks were displayed in the hallways of the centre. There was a private garden to the rear of the centre which was generally well maintained.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that there were systems for the assessment, management and ongoing review of risk. There was an up-to-date risk register in place which identified a number of risks. The risk register outlined the controls in place to mitigate the risks. The residents had a number of individual risk assessments on file, where required, which guided the staff team and were in the process of being updated.

Judgment: Compliant

Regulation 28: Fire precautions

The previous inspection found that significant improvement was required in the arrangements in place for the safe evacuation of all persons in the event of a fire, particularly at night time. This had been addressed following the inspection but due to the change in resident group was found to require further review.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a personal evacuation plan in place which appropriately guided staff in supporting residents to evacuate.

There was evidence of regular fire evacuation drills taking place. However, improvement was required in demonstrating that the arrangements in place for the

safe evacuation of all persons in the event of a fire during hours of darkness and when staff support is at its lowest were in place. For example, a night-time drill had not been completed since the new resident was admitted to the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed three of the residents' personal files. Each resident had a comprehensive assessment which identified the residents' health, social and personal needs. The assessment informed the residents' personal plans which guided the staff team in supporting residents with identified needs. However, a number of personal plans and related documentation such as risk assessments were overdue for review to ensure they were effective and accurate. This had been self-identified by the provider and there was evidence that the staff team were in the process of reviewing the personal plans.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The residents were supported to manage their behaviours and positive behaviour support guidelines were in place which appropriately guided staff in supporting the residents. There was evidence that the residents were supported to access behavioural support, psychology and psychiatry as required.

There were systems in place to identify, manage and review the use of restrictive practices. There were a number of restrictive practices in use in the designated centre which had been appropriately identified as restrictive practices and reviewed by the organisation's restrictive practice committee.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in place to safeguard residents. There was evidence that incidents were appropriately reviewed, managed and responded to. The residents were observed to appear content in their home and some residents spoke positively about living in the designated centre. The staff team had up-to-date training in safeguarding.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ceol OSV-0007747

Inspection ID: MON-0039399

Date of inspection: 23/05/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. PIC & SCW reviewed the actual and planned roster by 08.06.2024. A further review of staffing levels and rosters will be completed by PIC & ADOS by the 05.07.2024. This has been agreed as part of action planning from HIQA inspection and a follow up visit by the provider. 2. One (1) HCA (39hrs p/w) and one relief staff have commenced employment in Ceol 10.06.2024 and 12.06.2024, which has now reduced the vacancies and will support rostering of familiar staff in line with approved staffing levels. 3. The Person in Charge has returned from maternity leave to Ceol (39hrs p/w) on 04.06.2024, she will be PIC of one designated centre only. 4. Review of the Statement of Purpose completed to reflect adequate staffing level and funded WTE for the designated centre.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The PIC has reviewed the training report on 04.06.2024 and has sent email to individual team members to ensure HSELand refresher training is completed by 30.06.2024 2. Training and its importance will be discussed at the next team meeting on 17.06.2024 and will be added to all team meeting agenda going forward 3. Topic specific Quality Conversations will be completed with two team members who require training in de-escalation techniques 20.06.2024. On the job mentoring will be completed with one team member 20.06.2024. 4. De-escalation and Intervention techniques training (MAPA) has been scheduled for three employees on 04.09.2024 5. All employees will complete Introduction to Positive Behaviour Support (PBS) module by 05.07.2024	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The provider has moved to an on-line audit system (ViClarity) where a new template for the annual review has now been developed, which includes a section that identifies consultation with people supported and their representatives. This new audit has been fully implemented on ViClarity by 31.05.2024.
2. PIC will complete monthly finance audit on the four people supported files by 17.06.2024 and thereafter every month.
3. PIC will keep oversight of the monthly audits and will report on completion through PIC monthly status report to DOS/ADOS.
4. Aurora updated policy on Person Supported Personal Property, Finance & Possessions and this will be discussed at the next team meeting 20.06.2024 to ensure all employees have the knowledge and understand the processes within the policy.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
1. PIC will complete monthly finance audit on four people supported files by 17.06.2024 and thereafter every month,
2. PIC will keep oversight of the monthly audits and will report on completion through PIC monthly status report to DOS/ADOS.
3. Policy on Person Supported Personal Property, Finance & Possessions will be discussed at the next team meeting 20.06.2024 to ensure all employees have the knowledge and understand the processes within the policy.
4. The PIC will give On-the-Job mentoring to all the staff team on the appropriate recording and storage of receipts 27.06.2024.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Nighttime fire-drill was completed 09.06.2024.
2. PIC reviewed all PEEPs by 09.06.2024.
3. Further fire drills are scheduled on 12th July 2024 using different scenarios.
4. PIC has put fire drill schedule in place for the remainder of 2024 for planned fire evacuations.
5. The importance of scenarios for fire evacuation to be discussed at team meeting 17.06.2024.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. All risk assessments are currently under review and will be updated to ensure they are effective and accurate by 30.06.2024.

2. As per Personal Plan policy all Personal plans and supporting documents are currently under review to be completed 12.07.2024
3. Personal plan framework training will be completed by all team members by latest 13.08.2024.
4. Personal plan policy and related documentation had been discussed with the team at the next team meeting on the 17.06.2024.
5. Annul Review & Visioning meetings will be completed by 9.08.2024.
6. PIC will request all team members to read Personal Plan Policy, and will add to July team meeting agenda for further discussion and clarity that all team members understand the personal plan framework and the process to follow.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	27/06/2024
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	08/06/2024
Regulation 15(4)	The person in charge shall	Substantially Compliant	Yellow	03/07/2024

	ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.			
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	04/09/2024
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.	Substantially Compliant	Yellow	20/06/2024
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/05/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and	Substantially Compliant	Yellow	17/06/2024

	fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	13/08/2024