<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Teach Aislinn</th>
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<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0001894</td>
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<td><strong>Centre county:</strong></td>
<td>Kilkenny</td>
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<tr>
<td><strong>Type of centre:</strong></td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td><strong>Registered provider:</strong></td>
<td>Saint Patrick's Centre (Kilkenny)</td>
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<tr>
<td><strong>Lead inspector:</strong></td>
<td>Ann-Marie O'Neill</td>
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<td><strong>Support inspector(s):</strong></td>
<td>Laura O'Sullivan</td>
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<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>10</td>
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<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>0</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 26 February 2018 10:00
To: 26 February 2018 18:00

The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
</tr>
<tr>
<td>Outcome 05: Social Care Needs</td>
</tr>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 09: Notification of Incidents</td>
</tr>
<tr>
<td>Outcome 11. Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 12. Medication Management</td>
</tr>
<tr>
<td>Outcome 13: Statement of Purpose</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

Background to Inspection.
This inspection was an announced registration inspection that took place over one day. The centre had previously been inspected when it formed part of another designated centre. Subsequently, the provider reconfigured that designated centre and made two designated centres from the residential units that comprised it. Teach Aislinn is one of the original residential units that comprised St. Michael's Centre designated centre.

The provider had applied to register this centre under Section 69 of the Health Act 2007. The purpose of this inspection was to inspect the provider’s compliance with the regulations and standards and to assess if the provider had continued the positive improvements in compliance and outcomes for residents as were found on the previous inspection. 12 outcomes were reviewed during this inspection and actions from the previous inspections followed-up on to ensure the provider had completed them in line with their action plan response and timelines that had been agreed.
How we Gathered Evidence.
As part of the inspection, inspectors met with the recently appointed person in charge of the designated centre, nominated persons participating in management of the centre, staff, the director of services and quality and compliance manager.

Inspectors also met and spoke with all residents in the centre during the inspection. Residents’ specific communication repertoires meant they could not speak directly with inspectors or describe the service they were receiving. Inspectors at all times respected resident’s personal choice to spend time with them or not to during the inspection.

As part of the inspection, inspectors observed practices and reviewed documentation such as risk assessments, behaviour support plans, personal plans, healthcare plans, medication management systems and schedule 5 policies. Inspectors also carried out an observational review of the premises.

Description of the Service.
The centre comprises a one storey purpose built premises with two separate living areas, referred to in the report as residential units. The centre is located in the congregated campus setting of St. Patrick’s Centre, Kilkenny. The centre could accommodate up to 10 adult residents with varying degrees of intellectual disability and specific support needs in the management of healthcare, nutritional management, epilepsy and some behaviour support needs.

At the time of inspection there were 10 residents living in the centre. Since the previous inspection a number of residents had transitioned from the centre to new designated centres operated by St. Patricks’ Centre and located in the community. Residents currently living in the centre had transitioned from other designated centres on the campus in an effort to provide more improved living arrangements for them until they transitioned out of the centre to community residential setting homes.

This was part of St. Patrick’s overall de-congregation planning which had begun earlier in 2017. St. Patrick’s Centre had opened eight new designated centres since April 2017 registered by the Health Information and Quality Authority (HIQA) prior to residents moving in.

There were further plans to transition residents from this centre to community residential designated centres and transition planning was underway at the time of inspection, a number of residential properties had been identified by the provider and they intended to make applications to register the properties as designated centres in the coming months.

Overall Judgment of our findings.
Of the 12 outcomes inspected seven met with compliance or substantial compliance. Five outcomes met with moderate non-compliance.

Significant improvements had occurred in relation to fire safety containment and
detection measures in the centre and refurbishment and upgrade of the premises had occurred to bring it to an adequate standard. However, while improvements had occurred the premises still presented as institutional in nature and could not provide residents with an optimum home environment similar to their peers living in community residential homes.

Improved comprehensive assessment of residents’ social and healthcare needs, by a team of allied health professionals, had brought about improvement in personal planning for residents. This process now ensured support planning was evidence based to meet the assessed needs of residents. Through the assessment process some residents had been identified as requiring further medical investigations or treatment and this was being facilitated at the time of inspection through a person centred supportive process for those residents requiring such interventions.

Residents had also been identified as requiring specific behaviour support assessment and planning and at the time of inspection an assessment process was underway for some with support planning in place for other residents where required.

Improvement in meal provision had also occurred where residents’ meals were now cooked in the designated centre. This meant residents could smell and anticipate their meals and provided a more home like atmosphere in the centre. Some restrictions had also lessened. Doors to the kitchens were no longer locked at all times which meant residents had access to all areas of their home and engaged in cooking and baking activities in the centre.

Improvements were required in some areas.

Staff training required improvement to ensure staff had knowledge and skills to meet residents’ assessed needs, for example the management of dysphagia (compromised swallow) and administration of emergency medication for the management of seizures related to epilepsy. Improvement was also required for mandatory training in the areas of fire safety and safeguarding vulnerable adults.

While complaints were responded to an investigated documentation of the process required improvement. Documentation of fire drills was not adequate and did not provide enough information to identify the number of residents that participated in the drills and what learning had come about from the drill in order to improve fire safety practices.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.
Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Not all aspects of this outcome were reviewed on this inspection. Inspectors reviewed the management of complaints and privacy arrangements for residents living in the centre.

The complaints procedure was displayed in a prominent location in both residential units that made up the centre. This procedure was developed in an easy read accessible picture and written word format. It provided clear direction for residents, staff members and visitors on how to make a complaint, who the complainant could approach with a concern and how the centre and organisation would respond to and try to resolve the complaint. Nominated persons as part of the complaints process were clearly identified in the procedure.

However, improvement was required with regards to the implementation of the complaints process within the centre. Two complaints logged did not show evidence of review or resolution as no supporting documentation was available on site. Also, a complaint identified during the most recent six monthly provider led audit, February 2018, had not been entered into the complaints log maintained within the centre. This non-adherence to the complaints procedure had also been identified as part of the provider’s annual report for the centre, March 2017.

Natural privacy arrangements in the centre had improved since previous inspections of the centre. Each resident had their own bedroom, privacy curtains were in place and bathrooms and toilets provided suitable arrangements to ensure residents privacy and
dignity.

However, routine night time checks of residents while they slept were still ongoing in the centre.

Previously, staff had carried out one-hourly night time checks of residents. On this inspection these checks had been reviewed and now occurred every two hours. While this was some improvement, the rationale for these checks was still not clear. For example, all residents received two-hourly night time checks regardless of their assessed needs and specific personal risk presentations, which would identify if such observations were required or not.

The provider was required to continue to review and discontinue, where appropriate, this institutional practice for residents that did not require it. This was to ensure night time checks were based on an assessment of needs and identified personal risks for residents and to lessen un-necessary intrusion on residents' privacy and interruption of their sleep.

**Judgment:**
Non Compliant - Moderate

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**Outcome 04: Admissions and Contract for the Provision of Services**

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The provider had revised the contract of care for residents to ensure it contained transparent information with regards to the services provided in the designated centre.

From the sample reviewed residents' representatives had signed the contract.

In an effort to ensure transparency and uphold the rights of residents a sample of the contract of care had been issued to an external advocacy consultant to ensure the revised contract was fair and reviewed by a person acting in the best interests of residents and on their behalf.

This was an example of the provider promoting and recognising the rights of residents living in the designated centre.
**Judgment:**
Compliant

**Outcome 05: Social Care Needs**
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There was evidence to indicate allied health professional assessments of residents were ongoing and support planning to implement their recommendations were in place to guide staff in how to support those assessed needs. Out-of-date information had been archived and in general residents personal plans provided a clearer more concise plan of supports for each resident. Actions from the previous inspection had been addressed. Improvement was required with regards to person centred planning.

The inspector reviewed a sample of residents’ personal plans. Of the plans reviewed there was evidence that an assessment of residents’ social care needs had been carried out which identified residents’ specific needs.

All residents had received an annual multi-disciplinary allied health professional assessment from which their specific support needs were identified. Each month residents’ needs and support planning was reviewed through a multi-disciplinary allied health professional process. This was evidence of comprehensive review of residents' needs.

Overall, residents’ personal plans had improved in quality since previous inspections and detail provided in them ensured improved information for staff with regards to how to support residents and carry out allied health professional recommendations. Daily notes were documented to provide a running commentary of how residents’ days had progressed and evidence implementation of support planning.

Medication support planning was also in place. These plans outlined person specific supports and guidance to staff in how residents liked to receive their medication. Improvement was was required in relation to medications plans for the management of constipation and pain management to ensure a consistent approach was implemented.
For example, some residents were prescribed a number of different laxative or pain relief medications. Medication management plans did not set out clearly what medication staff were to administer as a first line of treatment and when to move onto the next medication in line with specific response criteria. This required improvement.

Person centred planning however still required improvement. Overall, there was a lack of person centred planning with residents and associated goal setting with action plans to achieve goals identified and timelines by when goals should be reviewed and who was responsible for the implementation of the actions identified.

**Judgment:**
Substantially Compliant

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**Outcome 06: Safe and suitable premises**
*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
As was found on previous inspections of this centre, the presentation, location and layout of the centre presented as institutional in nature and did not provide residents with the most optimum living environment similar to their peers living in community residential settings.

The provider had refurbished the premises and had installed wooden flooring throughout, painted and redecorated residents' bedrooms and communal spaces and installed windows that provided better heat and ventilation to the premises.

While these improvements were noticeable throughout, the premises was still institutional in presentation. All walls in the premises were bare breeze block walls which had been painted. Residents had limited access to outdoors and could only leave the premises with a member of staff. Communal living room spaces lacked a homely aesthetic and kitchen areas were somewhat limited in space.

There was evidence however, that maintenance issues were addressed in a timely way and equipment used in the centre had received up-to-date servicing, for example hoists.

Overall, the premises presented with a good standard of cleanliness.
A number of residents living in the centre had been identified to transition to community residential homes in the coming months with further transitions to occur for all residents before the end of 2018.

**Judgment:**
Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The health and safety of residents, visitors and staff to this centre was promoted and met to a good standard overall. Improvements were required in relation to documentation and frequency of fire drills and staff training in relation to fire safety. Not all staff had received up-to-date manual handling training.

Fire safety works improvement works were carried out since previous inspection had been completed by this inspection. Appropriate fire compliance and containment systems were in place in the centre. Each residential unit within the centre was fitted with a functioning fire alarm which had been serviced on a quarterly basis. Fire safety checks were carried out regularly and were up-to-date. Fire safety equipment such as fire extinguishers and fire blankets were located in the centre and serviced annually.

Fire drills with residents had been carried out and each resident had an up-to-date personal evacuation plan in place which set out supports required in the event of an evacuation of the centre being required. Some residents, though ambulant, required additional supports for evacuation purposes, these were documented in their personal evacuation planning. Some improvement was required in relation to fire drills. Documentation of the drills did not identify the number of residents that participated in the drill and did not provide adequate information to allow for analysis and improvements following each fire drill.

An up-to-date health and safety statement had been completed and a risk register was in place which detailed the risks and control measures specific to the centre and residents’ personal risks also. There was evidence which demonstrated the person in charge's understanding and competence in carrying out and analysing risks both environmental and personal risks for residents. The person in charge had also created standard operating procedures to guide staff in how to manage and respond to specific personal risks to residents. This was good practice and provided comprehensive guidance for staff.
The centre had recently transferred over to an electronic recording system for the recording of incidents and accidents. However, at the time of inspection this system was not fully up and running due to technical issues. While these were being addressed staff documented incidents that occurred in the centre on a paper based system which was found to be effective.

There was a policy on infection control. Cleaning schedules were in place and completed by staff on an on-going basis. Hand washing facilities in the centre were adequate. Hand wash and drying facilities were available to promote good hand hygiene. Colour coded mops and buckets were designated to clean specific areas in the centre to prevent cross contamination of surfaces. Where residents presenting with a personal risks which could pose also an infection control risk, the person in charge had developed standard operating procedural guidance for staff to ensure optimum management and prevention of infection risks.

Safe and appropriate practices in relation to manual handling were in place. Hoists were available in the centre and there was evidence of annual servicing of equipment to ensure they were all in working order. However, not all staff had received up-to-date manual handling training.

Judgment:
Non Compliant - Moderate

### Outcome 08: Safeguarding and Safety

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
There was evidence to indicate the provider had improved safeguarding practices within the centre in relation to restrictive practices and associated policies and procedures. There was also evidence of the implementation of National safeguarding vulnerable adults policy, procedures and reporting systems. However, improvements were required.

A restraint register was in place which detailed the current identified restrictive practices.
in place in the centre. The provider had also developed an assessment which staff completed to assess if a specific practice in place was a restrictive which in turn required specific control measures and management practices to ensure it's correct implementation. Overall, there were minimal restrictive practices in place with evidence of some previous institutional restrictive practices discontinued. For example, the kitchen was no longer locked at all times, this supported residents to have greater access to all areas of their home and engage in household activities such as food preparation and baking.

However, some improvements were still required. Not all restrictive practices in use were identified in the restrictive practice register. For example, the use of an infant monitor in a resident's bedroom was not identified as a human rights restriction. There was no clear rationale for its use documented in the resident's personal plan or a referral to and review by a human rights committee regarding it's use. While staff demonstrated to inspectors a rationale for why they used it, a restrictive practice assessment process had not been implemented to ensure it was used in the least intrusive way possible and alternatives trialled. This required improvement.

The provider had developed systems within Saint Patrick's Centre to implement the National safeguarding vulnerable adults policy. The policy was a printed copy of the HSE safeguarding vulnerable adults policy only. While this was acceptable in the main, the policy did not contain additional local procedural guidance for staff on how to implement the National policy within Saint Patrick's Centre designated centres. For example, the policy did not give guidance for staff on who the current designated officer(s) for Saint Patrick's Centre were, how to contact them and what localised reporting structures they were to follow. This was required to ensure staff were fully informed of how to implement National policy within Saint Patrick's Centre.

A sample of safeguarding plans was reviewed by inspectors. While it was evident that safeguarding allegations had been investigated and responded to as they occurred safeguarding plans did not give a descriptor of what the safeguarding risk for the resident was. Therefore, safeguarding plan guidance was not as effective as it could be in order to guide staff on how to mitigate and manage residents.

Not all staff had received up-to-date training in safeguarding vulnerable.

Personal and intimate care plans were in place and provided guidance to staff ensuring, consistency, privacy and dignity in the practice of providing personal care provided to each resident.

Positive behavioural support plans were in place if required by residents. Of those behaviour supports plans reviewed by inspectors they were found to be individualised and person centred in their approach. The plans gave clear guidance for staff on the support required by individuals with a clear descriptor of the behaviour of concern, proactive and reactive strategies. Plans were regularly reviewed by a behaviour support specialist to ensure that the changing needs of the residents were considered with each review of the plan.
Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Notifications received by the Chief Inspector had not been submitted within the assigned time lines required by the Regulations. Systems currently in place to ensure notifications were submitted on time required improvement.

Quarterly notifications submitted did not contain information with regards to all restrictive practices in use in the centre, for example an infant monitor was in place in a residents' bedroom however, this had not been notified as a restrictive practice.

Judgment:
Substantially Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Improvements in the overall comprehensive medical and allied health professional assessment of residents' healthcare had occurred and were still ongoing.

All residents had their own General Practitioner (GP) and had received an annual health check with them. Where required residents had also received blood tests and reviews of their medication. A yearly health assessment was also completed by staff using an 'OK Health Check' assessment tool.
As mentioned in previous inspection reports for St. Patrick's Centre campus designated centres, residents' access to and assessment by allied health professionals had improved significantly in the last year. Each resident was afforded a monthly allied health professional review whereby each resident's support needs were discussed and reviewed by the relevant allied health professionals associated with their care. This systematic and thorough review of each resident was reflecting positive and improved healthcare outcomes for residents.

On this inspection, inspectors observed residents were having an improved mealtime and nutrition experience within the centre. Food diaries maintained and documented residents engaging in home baking as part of an overall activity and sensory experience within the centre. This occurred during the course of the inspection where residents engaged in making chocolate brownies which resulted in a pleasant aroma in the centre and provided for a more homely environment.

With the de-commissioning of the centralised kitchen for the campus a member of the household staff now cooked residents meals within the centre. This inspection was the first inspection that the smell of cooked food was present. This was a significant improvement as it provided residents with a sense of anticipation for their meals and a sensory experience akin to any home environment of which they had not been afforded previously.

Meals provided were nutritionally balanced and prepared in line with recommendations from residents' speech and language therapist (SALT) and/or dietitian. Guidelines in relation to food and nutrition were available within individuals personal plans. Improvement was required in relation to staff training in the management of dysphagia (compromised swallow which can lead to the risk of choking). An action relating to this is assigned to outcome 17; Workforce.

Judgment:
Compliant

**Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Systems in relation to medication management were reviewed by inspectors. Over-all these were found to be efficient and safe. Good practice was observed in the storage,
disposal and supply of medications. Improvements were required in relation to liquid medications.

Equipment was available for crushing of medications as required and guidelines were available for staff in the administration of medications via a PEG tube (percutaneous endoscopic gastrostomy). Some review and improvement was required however in relation to the administration of medications via PEG tube, as not all medications administered had been prescribed in a liquid form and therefore were being administered in a manner not in line with the manufacturer's recommendations.

Medication administration sheets were clear with medication clearly identifiable from document. A signature bank was available of all nurses who currently administer medications within the centre. A medication fridge was available within the team leader office, however gaps were evident in relation to checking of the temperature of this.

Both internal and external audits had recently been completed by staff nurses and project lead. Action plans were developed as part of these audits with evidence of leaning and follow through of actions.

**Judgment:**
Substantially Compliant

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**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
A statement of purpose was available to inspectors as part of the inspection.

This document included a statement of the aim of the center and the facilities and services which were to provided to the residents.

The statement of purpose contained all information required under Schedule 1 of the regulations.

**Judgment:**
Compliant
Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Improved senior management governance systems in Saint Patrick's Centre were evident. Internal assurance processes were ongoing and carried out on a regular basis. However, there were some improvements required to ensure comprehensive governance and management quality assurance systems occurred operationally within the centre and also with regards to the frequency of provider led six monthly audits.

Since the previous inspection a new person in charge had been appointed who met the requirements of regulation 14 and its associated sub-regulations relating to management experience and qualifications.

Lines of authority, accountability and reporting structures for management of the centre were clearly delineated.

The person in charge was supported in his role by a clinical nurse manager 1 (CNM 1) who provided nursing oversight to the centre in compliment to the social care skills and experience of the person in charge. The person in charge reported to a community services co-ordinator manager. They knew residents and their families very well. The community services co-ordinator reported to the director of services.

The appointed community services co-ordinator also had relevant management experience and had a good understanding of regulation and monitoring centres for compliance with the standards and regulations.

Unannounced visits and audits by persons nominated by the provider, which are a requirement under Regulation 23 to gather information and assess the quality and safety of care, had been carried out since the previous inspection. However, only one six monthly audit had been carried out in the centre in 2017 this was not in line with the regulations. A recent six monthly audit had been carried out in February 2018 prior to the inspection. The audit was found to be informative and detailed with an associated action plan and persons responsible identified. At the time of inspection the person in charge and team leader for the centre were working on the audit findings.
Systems to assess the quality and safety of care in St. Patrick’s Service has improved greatly in the previous year with the appointment of a compliance manager, the appointment of key project co-ordinators with responsibility for assessing and supporting the implementation of actions identified in audits carried out and another project co-ordinator in the area of medication management and healthcare improvements and practice development in the service, for example.

Personnel from the management team for Saint Patrick's Centre carried out audits within the centre. While this was evidence of the provider's effective oversight of designated centres, the provider had not developed quality audit systems for the person in charge and team leader to implement on a day-to-day basis locally in the designated centre.

The provider was required to review the designated centre's operational management auditing system to ensure the person in charge and team leader consistently engaged in reviewing the quality of service provided to residents in addition to the provider's quality oversight system which was currently in place. This was to ensure the quality and safety of care, provided in the centre, was consistently and effectively monitored by all levels of management for the centre.

Judgment:
Substantially Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Improvements were required in relation to staff training in this centre. A significant number of gaps were evident with regards to both mandatory training and other specific training staff required to ensure they could effectively deliver evidence based and informed care to residents in line with their assessed needs and personal plans. Staff numbers on the day of inspection were not the whole-time equivalent staffing numbers set out in the statement of purpose for the centre.

Training gaps were evident in relation to all mandatory training for example, safeguarding vulnerable adults, manual handling and fire safety. Further gaps were
evident in relation to dysphagia (compromised swallow which may lead to a risk of choking), first aid and administration of emergency medication for the management of seizures associated with epilepsy.

Staff supervision systems were reviewed as part of the inspection. The person in charge acknowledged not all staff working in the centre had received an up-to-date supervision meeting. However, the person in charge had devised a supervision meeting schedule for the coming year and this was available for review during the inspection.

A sample of staff supervisions that had been completed were reviewed. They demonstrated the person in charge's competence in carrying out effective and comprehensive supervision meetings which in some instances had addressed difficult situations and discussions in a very respectful and professional manner giving concrete plans for moving forward with constructive feedback and guidance.

An actual and planned staff rota was in place and kept up-to-date.

A sample of staff files were reviewed. Some improvement was required. One file reviewed did not contain a satisfactory history of gaps in the person's employment history.

Staffing numbers in the centre were not in line with the whole-time-equivalent staffing ratio as set out in the statement of purpose for the centre. Therefore, staffing numbers were not always adequate to ensure residents engaged in activities outside of the centre due to staff shortages, for example.

**Judgment:**
Non Compliant - Moderate

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

Ann-Marie O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Saint Patrick's Centre (Kilkenny)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001894</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>26 February 2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>28 March 2018</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider was required to review night time checks for residents to ensure they were based on their assessment of needs and identified personal risks for residents.

1. Action Required:
   Under Regulation 09 (3) you are required to: Ensure that each resident’s privacy and

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
The service began to address this issue in 2016. At that time every person we support was checked on an hourly basis. Individual risk assessments were carried out with the resulting reduction of hourly to two hourly checks. The night check form is now used as evidence of the need or otherwise for checks and subsequently, will support the further reduction of night checks based on individual need.

Each person will have an individualised risk assessment and as a result an updated individualised night check schedule.

**Proposed Timescale:** 30/04/2018

**Theme:** Individualised Supports and Care

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Documentation of complaints, details of investigations carried out and their outcome, including the satisfaction of the complainant, required improvement.

2. **Action Required:**
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
Complaints log will be updated.
Follow up on the status of the two identified complaints has been done and both are now closed.

**Proposed Timescale:** 30/04/2018

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Improvement was required in relation to medication plans for the management of constipation and pain management to ensure a consistent approach was implemented and adequate guidance for staff was outlined.
3. **Action Required:**
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

**Please state the actions you have taken or are planning to take:**
A review of all medication plans will be conducted by both the PIC and the Clinical Nurse Manager of Teach Aislinn. Specific attention will be applied to pain management and the use of medications that relieve symptoms of pain and constipation.

Specific and individualized Standard Operating Procedures and Protocols will be developed, ensuring that staff have the procedural knowledge in the correct order for administration of medication.

**Proposed Timescale:** 30/04/2018

**Theme:** Effective Services

The **Person in Charge (PIC)** is failing to comply with a regulatory requirement in the following respect:
Person centred planning required improvement.

4. **Action Required:**
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

**Please state the actions you have taken or are planning to take:**
A new pathway has been developed, which facilitates each person to have a visioning meeting (facilitated by the Community Transition Co-ordinators). This will identify socially valued roles, which in turn, will then be developed into goals and action plans. This process which will be monitored by the PIC and T/L through individual Quality Conversation meetings and overseen by the Community Service Manager.

This more streamlined process, will support keyworkers with personal planning and meaningful and realistic goal setting. The keyworker is responsible for ensuring that the outcomes are met within the agreed timeframe.

**Proposed Timescale:** 30/06/2018

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

The **Registered Provider (Stakeholder)** is failing to comply with a regulatory requirement in the following respect:
The presentation, location and layout of the centre was institutional in nature and did not provide residents with the most optimum living environment similar to their peers living in community residential settings.

**5. Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**
An application to register a new home for two people from the centre is currently being prepared for submission to the regulator. All other people are engaged in their “My moving story” and are involved in the de-congregation process

**Proposed Timescale:** 31/12/2018

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received up-to-date training in manual handling.

**6. Action Required:**
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
An internal review of training procedures has been conducted in Teach Aislinn and all identified staff members who were not trained have now been trained or are booked onto mandatory training. A number of staff have since received dysphagia training, a number of staff have attended manual handling and safeguarding training. All staff will be trained by April 30th, 2018.

Each member of staff has been provided with a training schedule and must be accountable for their own training needs. Individual Training status be overseen by the PIC and addressed during Quality Conversations and team meetings. Training and Development is now a standard item on the agenda for each team meeting.

All staff will have received their mandatory training by 30 April 2018.

**Proposed Timescale:** 30/04/2018

**Theme:** Effective Services
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Documented fire drills required review and improvement to ensure information recorded evidenced the number of residents involved in the drill and their response to provide learning and information for reviewing of residents' personal evacuation procedures where required.

7. Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
Fire drills will be carried out monthly and all people being evacuated will be named as will the staff supporting them.
All the people we support must be accommodated in a fire drill, so that in the event of someone being absent, at the time of the drill, a subsequent drill will be completed to include the person who was absent previously.

Details of each person’s response during the drill will be recorded to inform appropriate review of individual PEEPs.

Training will be provided to all staff in respect of recording information and extracting learning from all fire drills, these discussions will take the format of discussions at team meetings and feedback at training days.

Proposed Timescale: 15/06/2018
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received up-to-date fire safety training.

8. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
All remaining staff, not currently trained, will have received fire training by the end of April 2018.

Proposed Timescale: 30/04/2018

Outcome 08: Safeguarding and Safety
**Theme: Safe Services**

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Not all restrictive practices in use in the centre had been identified.

A clear rationale for the use of some restrictive practices in place was not clearly documented.

**9. Action Required:**
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**
A review has been conducted by the PIC of the Risk Register. All restrictive practices with associated rationale have now been included onto the risk register. All restrictive practices have been assessed and guidelines put in place to meet the dignity, respect and privacy needs of the Residents. Each restrictive practice will continue to be monitored by the PIC, with the view of reducing restrictive practices in all cases as per restrictive practice policy. Reviews will be done every three months and each person will have a restoration of rights plan in place for each identified restriction.

Since inspection, St Patrick’s Centre has developed and implemented a service specific safeguarding procedure, in line with the National Safe Guarding of Vulnerable Adults Policy.

**Proposed Timescale: 30/04/2018**

**Theme: Safe Services**

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Safeguarding plans did not clearly define what each resident's safeguarding risk was.

**10. Action Required:**
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

**Please state the actions you have taken or are planning to take:**
The safeguarding risk will be clearly identified. In the event of a concern being identified an internal notification will be completed and the process followed as per St Patrick’s Safeguarding Procedure with the PIC/T/L and the designated officer. Since inspection, St Patrick’s has implemented a safeguarding procedure, in line with the National Safe Guarding of Vulnerable Adults Policy.
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<th>Proposed Timescale: 30/04/2018</th>
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<tr>
<td><strong>Theme:</strong> Safe Services</td>
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The safeguarding vulnerable adults policy did not give organization or centre specific guidelines for staff to follow.

**11. Action Required:**
Under Regulation 08 (5) you are required to: Ensure that the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child.

**Please state the actions you have taken or are planning to take:**
This has been addressed since inspection and is now completed. Please see 'St Patrick’s Centre safeguarding procedure’ attached.

Proposed Timescale: Completed

<table>
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<tr>
<th>Proposed Timescale: 03/04/2018</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Safe Services</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all staff had received up-to-date training in safeguarding vulnerable adults.

**12. Action Required:**
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**
A review by the PIC has been conducted and subsequently all team members (with the exception of one staff) have received training in Safeguarding.

The outstanding staff is scheduled for safeguarding training on the 10th April 2018. Following this date, all staff in Teach Aislinn will be trained in Safeguarding.

Proposed Timescale: 10/04/2018

| **Outcome 09: Notification of Incidents** |
| **Theme:** Safe Services |
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Notifications in some instances had been submitted outside time lines specified in the Regulations.

13. **Action Required:**
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
The PIC has been verified notifications since the inspection, allowing for clear lines of reporting responsibility and accountability. This has provided the centre with a more robust streamlined reporting structure. This position going forward will allow for compliance with all reports and notifications. Reporting time lines will be monitored by the Community Service Manager.

**Proposed Timescale:** 03/04/2018

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Quarterly notifications did not set out all restrictive practices in use in the centre.

14. **Action Required:**
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
All restrictions will be notified on the quarterly returns going forward and will be cross checked with the centre’s restrictive practice register. Each restrictive practice will be reviewed on a quarterly basis and have a documented restoration of rights plan in place. Quarterly status reports will be provided to the Inspector.

**Proposed Timescale:** 30/04/2018

**Outcome 12. Medication Management**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication fridge temperatures were not recorded on a daily basis.
15. **Action Required:**
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
The PIC has informed all staff of the requirement to record “fridge temperatures”. This information has been delivered in the forums of Team meetings and individual staff Supervision sessions. The checking of fridge temperatures has been delegated to a team member with responsibility to record same. The PIC will monitor this as a routine ongoing task.

**Proposed Timescale:** 03/04/2018

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all medications administered by PEG tube were prescribed in a liquid form and therefore were being administered in a manner not in line with the manufacturer's recommendations.

16. **Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
Since inspection all medications that are available in liquid form are now in use for the person who receives medication via PEG.

One medication is still in tablet form and this issue has been discussed with both the GP and the pharmacist who are in agreement that this is the most effective form to administer this medication.

Written confirmation re this has been sought from both parties and the PIC will follow-up to ensure this is clearly documented on the person’s file.

**Proposed Timescale:** 20/04/2018

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**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory
requirement in the following respect:
The provider was required to review the designated centre's operational management auditing system to ensure the person in charge and team leader consistently engaged in reviewing the quality of service provided to residents in addition to the provider's quality oversight system currently in place.

17. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
St Patrick’s Centre has developed an auditing schedule, which clearly identifies auditing responsibility at each level of management to include the Providers responsibility. See attached.

**Proposed Timescale:** 03/04/2018

**Theme:** Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Provider led unannounced visits to the centre had only occurred once in 2017.

18. **Action Required:**
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

**Please state the actions you have taken or are planning to take:**
All provider audits announced and unannounced will be completed in line with the Regulations. The provider will maintain a data base of provider audits to ensure that all audits are carried out at appropriate intervals. Where this auditing process is delegated to a senior manager the provider will review the report and follow up on any areas of non-compliance with the Director of Service. The Quality and Compliance department will monitor the follow-up actions to ensure all issues have been addressed in a timely fashion.

**Proposed Timescale:** 03/04/2018

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
requirement in the following respect:
Staffing numbers in the centre were not in line with the whole-time-equivalent staffing ratios set out in the statement of purpose for the centre.

19. Action Required:
Under Regulation 15 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:
Recruitment is in process at present to address the skill mix and whole time equivalent deficits.
The PICs T/Ls have weekly meetings with their HR business partners where they highlight staff whole time equivalent deficits. The SOP staffing ratios will be updated to reflect the current (temporary) staffing deficits.
Regular agency staff (as an interim measure) are in place while awaiting satisfactory recruitment.

Proposed Timescale: 30/05/2018
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff files did not contain adequate information in relation to employment history gaps for staff.

20. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
HR dept have reviewed each file and have taken appropriate steps to ensure all documentation is present.

Proposed Timescale: 03/04/2018
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement was required for staff training in mandatory training and further training specific to meet the needs of residents.

21. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional
Please state the actions you have taken or are planning to take:
Since the inspection training has been ongoing
Children's First: 100% complete.
Fire training: Two staff outstanding and booked for 27th April
Manual handling: One person booked for 17th April
Safeguarding: 1 person booked for 10th April.
This will ensure all staff are compliant in mandatory training.

**Proposed Timescale:** 30/04/2018

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff working in the centre had received a supervision meeting with their manager.

22. **Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
A schedule has been developed where each team member has a date for their six-weekly quality conversation meeting.
See Quality Conversation Draft Policy, attached.

**Proposed Timescale:** 01/05/2018