



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

Name of designated centre:	Tóchair
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	20 June 2018
Centre ID:	OSV-0005699
Fieldwork ID:	MON-0024271

About the designated centre

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

Tóchair designated centre provides community based living arrangements for up to four adult residents of female gender only. This service provides supports for residents with severe to profound intellectual disabilities and complex needs. The provider identifies that residents living in this centre require high levels of support and assign two staff to work in the centre during the day with a third staff available to support residents in having a full and active life. One waking night staff works in this centre at night time. A full-time person in charge is assigned to this centre. The centre is supplied with one transport vehicle to support residents' community based activities. Tóchair designated centre is a spacious, bespoke property that provides residents with a high standard living environment which can meet their assessed mobility and social care needs. Each resident has their own bedroom and private en-suite facilities are available in each bedroom.

The following information outlines some additional data on this centre.

Current registration end date:	18/12/2020
Number of residents on the date of inspection:	4

How we inspect

To prepare for this inspection the inspector or 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
20 June 2018	10:20hrs to 17:20hrs	Ann-Marie O'Neill	Lead

Views of people who use the service

Residents living in this centre were unable to verbally communicate to the inspector their experience of living in the centre. It was demonstrated that residents appeared relaxed and comfortable in their home. Residents were observed going on outings from the centre during the day while others were supported to stay in the centre as part of their convalescence following a recent medical procedure.

Capacity and capability

The provider had systems in place to ensure the centre was regularly monitored and reviewed from a provider level. Inspection findings demonstrated the provider was implementing consistent monitoring and oversight of the service which in turn had led them to identify a more robust operational management arrangement was required to bring about improved quality of life outcomes for residents living in the centre. The provider had responded to this by instating a full-time person in charge for this centre. This arrangement had occurred the week of the inspection and the newly appointed person in charge was involved in a hand over process at the time of inspection.

Overall, the inspector found evidence of a responsive, fit provider capable of monitoring its own governance arrangements and where necessary taking responsive action to improve services provided to residents.

A clearly defined management structure was in place which ensured lines of accountability and authority within the centre. The person in charge had responsibility for this designated centre and one other designated centre a short distance away. They were supported in their role by a community services manager. The person in charge met the requirements of regulation 14 in relation to relevant qualifications and management experience. The provider had also ensured performance management arrangements were in place to supervise the person in charge and monitor the quality of care in the centre on a consistent and regular basis.

A provider led audit programme was in place to ensure key quality areas of practice were regularly monitored and reviewed. A suite of audits had been carried out and provisions were in place to ensure a six monthly provider led audit and annual report would be completed to meet the regulatory requirements of Regulation 23.

Effective staffing arrangements ensured that the number and skill-mix of staff working in the centre met the assessed needs of residents ensuring they received

the continuity of care and support they required. In response to some incidents that had occurred staffs' day shift finished later at night time to ensure an adequate number of staff were in place to support residents until they retired for bed. This staffing resource change had reduced the number of incidents after it had been initiated.

Training and development systems for staff were also effective. Staff had received a formal supervision meeting in the previous months. All staff had received training in mandatory areas such as fire safety, safeguarding vulnerable adults and manual handling. The provider had also ensure staff had received training in other areas specific to residents' assessed needs, for example training in first aid and supporting residents with dysphagia (risk of choking due to compromised swallow). Some improvement was required to ensure all staff had training in food hygiene and safety.

A sample of incidents reports were reviewed and it was identified that all notifiable incidents had been submitted to the Chief Inspector as required by the regulations.

The provider had ensured the statement of purpose was updated to reflect the new governance arrangements in the centre. The revised statement of purpose was submitted to the Chief Inspector and found to meet the requirements of Schedule 1 of the regulations.

Regulation 14: Persons in charge

The provider had instated a full time person in charge with responsibility for this designated centre and another designated centre located a short distance away. They were found to meet the requirements of regulation 14 in relation to experience and qualifications.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured an adequate staff number and skill mix for the centre. A planned and actual roster was in place. It had been identified that residents required supports until later in the night time and staff shift hours had been adjusted to meet the needs of residents in this regard. Schedule 2 files were not reviewed during this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received training in mandatory training areas such as safeguarding vulnerable adults, manual handling and fire safety. Some further training had been provided in dysphagia management and first aid. Not all staff had received training in food hygiene which was a training requirement identified by the provider for staff working in this designated centre.

Staff had received supervision meetings and these were documented.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had made necessary operational management governance arrangements and had instated a full time person in charge of the centre. The provider had met their regulatory requirements and had completed an annual report for the centre and a number of quality audit checks to monitor the safety of care provided in the service. Operational management auditing systems were in place which would be the responsibility of the person in charge to complete as per the provider's governance and management assurance systems.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was revised to reflect the new operational governance structure in the centre and submitted to the Chief Inspector in line with the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

All required notifications had been submitted to the Chief Inspector.

Judgment: Compliant

Quality and safety

It was demonstrated on this inspection that residents were provided a good service with some improvements required to ensure the quality and safety of care provided to residents at all times. Risk management systems for the prevention and response to falls required more robust mitigation and response management planning. Fire evacuation procedures at night time required review to ensure they were as effective as possible.

Overall, it was clearly demonstrated residents were experiencing better quality outcomes in their daily lives since moving from Saint Patrick's Centre congregated setting. The provider had ensured residents were provided with a quality home which could support residents' social care needs and integration with their local and wider community. The location of the centre ensured residents had greater opportunities to integrate with their local community. Since moving into their new home residents had been supported to meet their neighbours and wider community. Residents with the support of staff had held a successful coffee morning in the centre where over 40 local people attended.

The provider had ensured residents received a comprehensive assessment of needs through an allied health professional framework. Residents' personal plans were comprehensive and demonstrated residents assessed needs were reviewed regularly with updated recommendations provided following each review. This ensured residents best possible physical and mental health outcomes were being achieved and continuously monitored to a good standard in this centre. Residents also received improved quality meal provision in line with their assessed dietary requirements and in consistencies that met their needs.

While residents' assessed needs were identified and reviewed regularly it was not demonstrated the same quality of provision was in place to ensure their identified goals were implemented and reviewed. Each resident had received a comprehensive person centre planning meeting at which meaningful goals were identified for them. While this comprehensive work had been carried out, an action plan with review dates and persons responsible for supporting the resident to achieve these goals had not been put in place. It was also not demonstrated that residents were being supported to achieve a meaningful day on a consistent basis.

The provider had ensured National safeguarding vulnerable adults policies and procedures were in place which were supported by an organisational policy which set out localised reporting procedures. Intimate care planning was comprehensive and described residents levels of independence and required supports.

Overall, it was demonstrated a low level of restrictive practice was used in the centre. There was evidence of some restrictive practices associated with the use of bed rails were being reviewed with a view to reducing the amount of time they were used for on a gradual basis. If and where required residents had access to qualified and experienced allied health professionals for the promotion of their best possible

health and behaviour support planning. In other instances the use of PRN (as required) chemical restraint had been discontinued as it was deemed no longer required. This was evidence that residents' new home, staffing arrangements and service provision was better meeting their assessed needs.

The provider had ensured appropriate fire safety precautions and containment measures were in this centre and met the regulations. Fire safety equipment was serviced as required and a functioning fire alarm was present in the centre. However, night time evacuation procedures were not demonstrated as being effective. It was also not clearly demonstrated what evacuation aids had been trialled to ensure they were the most effective option for each resident to ensure efficient evacuation. A recent night time fire evacuation drill had taken over 12 minutes to complete.

A risk management policy that met the requirements of the regulations was in place. However, some aspects of its implementation in the centre required improvement. As part of the provider's overall risk management systems and electronic incident recording system had been implemented across the service and was in place in the designated centre. Falls risk management presented as a key risk for residents living in the centre. While an effective falls risk assessment was in place, it was not demonstrated that effective and proactive mitigation strategies had been put in place in response to the outcomes of the assessment or as a response to a recent number of slips and fall incidents that had occurred in the centre.

Regulation 17: Premises

The designated centre met the assessed needs of residents and provided adequate space to support residents' prescribed mobility programmes. Overall, the premises was maintained to a good standard throughout and residents' bedrooms were personalised and spacious.

Judgment: Compliant

Regulation 26: Risk management procedures

Some improvement was required to ensure robust mitigation and management systems were in place for the risk of slips and falls.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had ensured appropriate fire safety precautions and containment measures were in place. It was not demonstrated that residents had been adequately assessed for the type of evacuation aid they may require to ensure effective and timely evacuation from the centre. A recent fire evacuation drill carried out to simulate a night time evacuation did not provide adequate assurances that an effective evacuation procedure was in place.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Appropriate and safe medication management systems were in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had received a comprehensive assessment of need and it was evidenced that these needs were reviewed on a monthly basis through an allied health professional multi-disciplinary process. Person centred goal planning had occurred and it was demonstrated that goals for residents had been identified. Improvements were required to ensure action planning was in place to meet the identified goals for residents. Residents did not consistently engage in a meaningful day within the centre and activities they engaged in were not geared towards achieving goals identified for them.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare was managed to a good standard and it was clearly demonstrated the provider had measures in place to ensure they achieved their best possible health.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required residents had access to allied health professional supports to ensure their best possible mental health and to provide behaviour support planning. Appropriate systems were in place for the management of restrictive practices with evidence of some restrictive practices being reduced gradually.

Judgment: Compliant

Regulation 8: Protection

The provider had appropriate safeguarding vulnerable adults systems, policies and procedures in place. Intimate care planning was in place and comprehensively described the level of independence and types of supports required by residents. All staff working in the centre had received training in safeguarding vulnerable adults.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tóchair OSV-0005699

Inspection ID: MON-0024271

Date of inspection: 20/06/2018

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Staff are supported to attend mandatory and mandated training/courses. It is also the responsibility of staff to propose training that would enhance and support their role within St. Patrick's Centre (Kilkenny).</p> <p>A centre specific training profile, individual staff training profiles and a training schedule are distributed monthly to the PIC and CSM of the centre by the Training Department. Staff training is on the agenda of the monthly team meetings.</p> <p>Training Update:</p> <ul style="list-style-type: none">- All staff will have completed mandatory training by the 24/08/2018- Staff are booked in for Food Hygiene Training Level 1. All staff will have completed the training by the 31/08/2018. <p><i>Please see attached list of training for staff.</i></p> <p>There is a Quality Conversations policy in place. The policy outlines a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for staff. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.</p> <p>The Team Leader has a schedule for the 6weekly Quality Conversations with the staff in the centre.</p> <p><i>Please find attached the schedule for this designated centre</i></p>	

Regulation 26: Risk management procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <p>The newly appointed PIC in the designated centre has a monthly work plan schedule in place to monitor meetings between the PIC and the Team Leader.</p> <p>This schedule reflects the following:</p> <ul style="list-style-type: none"> • dates and tasks of meetings between the PIC and the Team Leader • agreed actions • update on progress of actions <p><i>Please find a copy of the work plan schedule attached.</i></p> <p>As part of this work plan, the PIC and Team Leader met on the 19/07/18 to review all risk assessments and update the risk register.</p> <p>Robust mitigation and management systems are in place for the risk of slips, trips and falls.</p> <p>The Team Leader and delegated staff will review and monitor all risk assessments on a three monthly basis or immediately where required.</p> <p>A review of incidents takes place in the designated centre at monthly team meetings. </p>	
Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>A night time fire drill was held on the 25/06/18.</p> <ul style="list-style-type: none"> • Dates, times and staff involved in the drill was documented • Behavior and reactions of the people supported were documented. • The type of evacuation aid they may require was assessed. • Learning from the drill took place with the team <p>An effective evacuation procedure is in place now. The CEEP was updated regarding:</p> <ul style="list-style-type: none"> • The evacuation aid for the people supported • Staffing requirements and responsibilities <p>Learning from the fire drill was discussed at the team meeting on the 24/07/18.</p> <p>The Standard Operating Procedure was updated. It incorporates the response of staff from another designated centre in the case of an emergency.</p> <p>The PIC and Team Leader are organising a house tour on the 20/08/18 for on call staff from the other designated centre in order to become familiar with the designated centre.</p>	

Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>As a result of the monthly work plan schedule the Community Service Manager, PIC and Team Leader attended the team meetings on the 19/06/18 and the 24/07/2018 to review individual assessment and personal planning with the staff.</p> <p>Following was discussed at this meeting:</p> <ul style="list-style-type: none"> • Action plans for all goals identified in the visioning meetings for the people supported are in place • Responsibilities for staff and time frames were agreed • The PIC and Team Leader gave guidance to staff regarding the completion of action plans for the identified goals • The Quality Conversations Policy was discussed to support staff in their role • All steps completed towards achieving identified goals are evidenced through the 'Conditions for success forms' and these are then reviewed to evidence preferences and choice. <p>The standard of reviewing these goals is on a three monthly basis. The Team Leader is supporting the key worker through 6 weekly Quality Conversations to achieve the goals with the supported person.</p> <p>The Team Leader has an audit schedule in place to review all personal files. As a result of this audit the Team Leader has written recommendations for the keyworker which will be reviewed at the Quality Conversations. Through the monthly work plan schedule the PIC is monitoring this process.</p> <p>Visioning meeting reviews are taking place every 6 months.</p> <p>Within the Person Supported Pathway to MDT each person has a monthly in house review meeting, where current issues and needs are discussed and agreed. The keyworker and PIC attend an annual MDT review meeting.</p> <p>All these meetings ensure that the supported person's personal plan is not only the subject of a review by the keyworker and PIC, but also by appropriate health care professional to reflect changes in need and circumstances. </p>	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(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	31/08/2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	19/07/18
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where	Not Compliant	Orange	25/06/18

	necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	24/07/18