Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Ohana
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	20 March 2025
Centre ID:	OSV-0007781
Fieldwork ID:	MON-0045441

About the designated centre

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

Ohana is a designated centre operated by Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities. The designated centre provides community residential services to two adults with a disability. The designated centre comprises of two single occupancy apartments located next to each other in a town in County Kilkenny. Each apartment consists of a kitchen, sitting room/dining room, individual resident bedroom, sensory room and a bathroom. There are gardens to the rear of the apartments for the residents to use if they wish. The centre is staffed by the person in charge, social care workers, staff nurse and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 20 March 2025	10:20hrs to 17:50hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was carried out with a specific focus on safeguarding, to ensure that residents felt safe in the centre they were living in and they were empowered to make decisions about their care and support. The inspection was carried out in one day by one inspector.

The inspector had the opportunity to met with the two residents in their apartments throughout the inspection as they went about their day. The residents used verbal and alternative methods of communication, such as vocalisations, facial expressions, behaviours and gestures to communicate their needs. The inspector also met with four staff members and reviewed records pertaining to the care and support and governance arrangements in the centre.

On arrival to the first apartment the inspector was welcomed by the resident who was spending time in the sitting room. The inspector sat in the living room with the resident as they listened to the radio, played music on their keyboard and planned their day with the staff member. The resident appeared comfortable in their home and planned to access the community later in the morning to go for a walk and shopping. The inspector was informed the resident planned to visit a relative later in the day.

The inspector carried out a walk through of the apartment which consisted of an open plan kitchen/sitting/dining room, individual resident bedroom, sensory room and a bathroom. Overall the apartment was well maintained and decorated in line with the residents preferences.

Later in the morning, the inspector met the second resident in their apartment. The inspector spent time in the sitting room and observed the resident engaging with sensory equipment on the walls in the living room as they moved around their home. The resident was supported to leave the centre to attend an appointment. In the afternoon, the resident returned home for lunch as was observed spending time in the sitting room and sensory room.

The inspector carried out a walk through of the second apartment. Similar to the first apartment, the apartment consisted of a sitting/dining room, individual resident bedroom, sensory room and a bathroom. However, an internal wall had been installed to create a galley kitchen separate from the sitting/dining area in order to manage identified risks. The inspector was informed that the resident still could access the kitchen area accompanied by staff. At the time of the inspection, the provider was in the process of reviewing the internal wall to ensure the design and layout of the apartment was proportionate to the risk and was the least restrictive measure.

Overall, the inspector found that the two apartments were decorated in a homely manner with residents' personal belongings and pictures of the residents and their

family. However, the back garden in one of the apartments required attention. For example, the back garden for one of the apartments was prone to flooding which negatively impacted the resident who liked movement and activity. This had been self-identified by the provider and plans had been developed plans to address the flooding in the garden and install sensory equipment. However, at the time of the inspection there was no identified start or end date to have the back garden addressed.

Overall, based on what the residents communicated with the inspector and what was observed, the residents received good quality of care and support. The residents appeared content and comfortable in the service and the staff team were observed supporting the residents in an appropriate and caring manner. However, some improvement was required in training and development, governance and management and the premises.

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

Capacity and capability

There were management systems in place to ensure that the service provided was safe, consistent and appropriate to the residents' needs. On the day of inspection, there were sufficient numbers of staff to support the residents assessed needs. However, some improvement was required in the training and development of the staff team and governance and management.

There was a defined management structure in place. The person in charge was in a full time role and they held responsibility for the day-to-day operation and oversight of care in this and one other designated centre operated by the provider. There was evidence of regular quality assurance audits taking place to ensure the service provided was appropriate to the residents needs and actions taken to address areas identified for improvement. However, the effectiveness in addressing areas for improvement required improvement.

The inspector reviewed the staff roster and found that the staffing arrangements in the designated centre were in line with residents' needs. Staff training records were reviewed which demonstrated that staff were up-to-date with the majority of identified training and suitably supervised. However, some improvement was required to ensure all staff had up-to-date training in de-escalation and intervention techniques.

Regulation 15: Staffing

The registered provider ensured that the number, qualifications, skill mix and experience of staff was appropriate to the assessed needs of the residents. The staffing arrangements were organised to reduce the risk of harm and to promote the rights, health and wellbeing of each person.

The person in charge maintained a planned and actual roster. From a review of the previous two months of rosters, the inspector found that there was an established staff team in place. At the time of the inspection the centre was operating with one vacancy and one staff on approved leave. The roster demonstrated that the vacancy and leave was covered by the staff team and regular relief staff. This ensured the continuity of care and support to the residents. The inspector was also informed that the vacancy had recently been filled. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner.

The registered provider ensured that there were sufficient staffing levels to meet the assessed needs of the residents. The two residents in this service did not attend any formalised day services or work during the day. While they could access sessions in the day service, they were reliant on the staff team for activation. In the first apartment, the resident was supported on a one to one basis. A second staff member was available for 30 hours during the week to support with activation. In the second apartment, the resident was supported on a two to one basis during the day. Each resident was supported by a waking night staff at night.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. From a review of the training records for the staff team, it was evident that the staff team in the centre had up-to-date training in areas including safe administration of medication, manual handing, fire safety and safeguarding. In addition, a number of the staff team had completed training in human rights. This meant the staff team were provided with the required training to ensure they had the necessary skills and knowledge to support and respond to the needs of the residents and to promote their safety and well being. However, some improvement was required to ensure all staff had up-to-date training in de-escalation and intervention techniques.

There was a supervision system in place and all staff engaged in formal supervision. From a review of records it was evident that the staff team were provided with supervision in line with the provider's policy. There was a scheduled of supervision meetings planned for the rest of the year.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge was responsible for one other designated centre.

The person in charge was aware of the assessed needs of the residents and was supported in their role by the staff team. The residents were observed to be relaxed and comfortable in the presence of management and the staff team. The staff members spoken with also reported that they felt supported to carry out their roles by the systems in place.

The designated centre was being audited as required by the regulations and an annual review of the service had been complete for 2024 along with a six monthly unannounced provider visits to the centre carried out in June 2024 and January 2025. These audits were to ensure the service was meeting the requirements of the regulations and was safe and appropriate in meeting the needs of the residents. However, some improvement was required in the effectiveness of addressing areas identified for improvement. For example, the back garden in one of the apartments was identified as an area for improvement for a prolonged period of time. While there was evidence that some actions had been taken, at the time of the inspection the issue remained ongoing and had a negative impact on the resident living in the apartment. The provider had developed plans to address the flooding in the back garden and install sensory equipment, however there was no identified start or end date for the plans.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that the staff team were striving to provide safe and person centred care to the residents in this centre. However, some improvement was required in the premises.

The inspector reviewed the personal plans for both residents and found that they were up to date and provided clear and comprehensive guidance to staff team in supporting the residents with their personal, social and health needs.

There were systems in place to ensure residents were safe. The staff team had up to date training in safeguarding and demonstrated knowledge on what to do in the event of a concern. The staff spoken with were knowledge of residents and their communication and needs. There were systems in place for identifying, managing and responding to risk.

Regulation 10: Communication

The residents used verbal and alternative methods of communication, such as vocalisations, facial expressions, behaviours and gestures to communicate their needs. Each residents' communication needs were outlined in their personal plans which guided the staff team in communicating with the resident. The staff team spoken with demonstrated an clear understanding and knowledge of the residents communication methods and were observed communicating with residents throughout the inspection.

Judgment: Compliant

Regulation 17: Premises

The designated centre comprises of two single occupancy apartments located next to each other. Each apartment consists of a kitchen, sitting room, dining room, individual resident bedroom, sensory room and a bathroom. Overall, the designated centre was well maintained and decorated in a homely manner with resident pictures and belongings.

However, the design and layout of aspects of the apartments required review. For example, the back garden in one of the apartments was prone to flooding which negatively impacted the resident, who enjoys movement and physical activity, to use the space. While there was evidence of previous actions taken, this area required continued attention.

In addition, an internal wall had been installed in one to the apartments to create a galley kitchen separate from the open plan sitting/dining room. This was in place to manage identified risks. While, the wall was decorated in a homely manner with panelling and personal pictures, the design and layout of the environment require review to ensure it was proportionate to the risk present and was the least restrictive environment. This had been self-identified by the provider.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had systems in place to identify and manage risk and keep the residents safe in the centre. There was a policy on risk management in place in the centre.

The inspector reviewed the risk register and found that general and individual risk assessments were in place. The inspector reviewed a sample of risk assessments in place and found that they reflected the risks present, the control measures in place and were up to date. For example, there were up-to-date risk assessments in place in relation to feeding eating and drinking supports, falls and behaviour.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the two residents' personal files. Each resident had a comprehensive assessment which identified the residents health, social and personal needs. This assessment informed the residents' personal plans to guide the staff team in supporting residents' with identified needs and supports. The inspector found that the person plans were up-to-date and reflected the care and support arrangements in place.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' were supported to manage their behaviours and positive behaviour support guidelines were in place, as required. There was evidence that residents were supported to access psychology and psychiatry, as required.

There were a number of restrictive practices in place in the centre. The restrictive practices were identified, reviewed and implemented in line with the provider's policy. There was evidence of efforts made to reduce and remove the use of restrictive practices. For example, a trail had been completed on the removal of a transport harness for one resident and plans were in place to reduce and remove a fob on the kitchen door in the apartments.

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents. For example, there was a clear policy in place, which clearly directed staff on what to do in the event of a safeguarding concern. There was evidence that incidents were appropriately reviewed, managed and responded to. All

staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with during this inspection demonstrated a good awareness of how safeguarding concerns were to be reported.The residents were observed to appear content and comfortable in their home.

Judgment: Compliant

Regulation 9: Residents' rights

A rights based approach to care and support was well adopted within this centre. The staff team had a keen awareness of the residents assessed needs and promoting residents rights. All staff spoke about residents in a professional and caring manner. Residents were supported with activation by the staff team from the designated centre. The inspector observed the staff team discussing and planning the activities for the day with the residents supporting residents to make decisions about their care and support. All interactions between staff and residents were kind, respectful and in line with resident needs.

Documentation in relation to residents was written in a person-centered manner. Residents confidential information was kept safe and secure.

The staff team were supported to completed training in human rights.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ohana OSV-0007781

Inspection ID: MON-0045441

Date of inspection: 20/03/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Improvements were required in training for team members of de-escalation and intervention techniques. On review and further discussion with the Ohana team and training coordinator, more team members have since completed their de-escalation and intervention techniques via CPI MAPA training within Aurora and one relief staff had completed CPI MAPA training externally. Outstanding training has been planned for two relief staff in the coming weeks, one scheduled for 14th May 2025 and the second scheduled for 10th June . One team member, currently completing aNursing Sponsorship has completed a PMAV training externally through one of her University Nursing modules, this will be accepted until training can be attended in August 2025 (when team member is available to attend within college remit). This team member will also complete a Microsoft teams' session with Aurora Behaviour Support Specialist while CPI MAPA training is outstanding.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider acknowledges the effectiveness of addressing areas already self-identified for improvement including the back garden in one of the gentlemen's homes is taking some time to resolve due to factors outside of Aurora remit. External factors including lack of landlord involvement/ support, height of the GAA pitch over the back garden, lack of additional HSE funding to the provider and difficulties to obtain external quotes for work required. The provider has discussed this gentleman's home including his garden in Aurora's housing meetings and further steps have been taken, such as: Aurora's Director of Strategic development has met with the local authority's Senior	

County Engineer. They in turn have sought advices from their Executive Landscape Architect in Capital Delivery Office & Parks who have recommended a company who would be able to supply appropriate surface for the garden. The provider will endeavour to obtain three quotes for the above. One has been obtained to date.
The council Engineer has also sought advices from the Adaptations Team within the council to see if we can apply for grant funding for this surface and is awaiting their response.
Should the provider not be able to secure grant funding, the provider may have to submit a business case on behalf of the gentleman living in Ohana to the HSE for additional funding to complete the works.

The WCI manager will keep the PIC, team and person supported informed about the above steps and developments.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The premises in relation to managing identified risk to one person support in Ohana, requires ongoing review. To ensure that risks are identified appropriately and analysed to take the necessary steps for any amendments in the person's home, following is currently in process:

The provider has agreed with the PIC to arrange a full MDT meeting for 19th May 2025. The supporting team in Ohana, have been collecting data on person supported behaviours and potential risks. This will be reviewed by Aurora's Behaviour Support Specialist and discussed in detail at this MDT meeting. The person's consultant psychiatrist who has huge involvement in the person's life will be attending along with Aurora's Human rights and equality lead personnel, who also is involved on the restrictive practice committee.

Since, this inspection, the CEO has again visited Ohana and spoke directly with the person supported and direct support team on areas of restriction in his home and how the team do promote the reductions of restrictions daily, while maintaining safety.

Overall, the provider, MDT team, PIC and support team will ensure the risk is most appropriate and proportionate to the actual risk for the gentleman living in Ohana.

The gentleman's physiotherapist was contacted in relation to recent discharge and explained a risk in relation to the person's gait. A request has been made for support in relation to an application for adaptations, based on this changing need for the person's mobility.

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	01/08/2025
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/07/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	31/07/2025

	state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/07/2025