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:	Ardeevin
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	09 July 2021
Centre ID:	OSV-0005777
Fieldwork ID:	MON-0033346

About the designated centre

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

Ardeevin designated centre is operated by Saint Patrick's Centre (Kilkenny). It provides a community based residential service to up to four adult residents. Ardeevin is a modern and spacious property that provides residents with a high standard living environment which meets their assessed mobility and social care needs. Each resident has their own bedroom. 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 has staffing arrangements in place to ensure residents' needs are met. There is a full-time person in charge assigned to the centre, minimum of two staff during the day to support residents in having a full and active life and one waking night staff in place also. The centre is resourced with one transport vehicle to support residents' community based activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 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
Friday 9 July 2021	10:00hrs to 15:50hrs	Conan O'Hara	Lead
Friday 9 July 2021	10:00hrs to 15:50hrs	Sarah Cronin	Support

What residents told us and what inspectors observed

This inspection took place during the COVID 19 pandemic. As such, inspectors followed public health guidance and HIQA enhanced COVID-19 inspection methodology at all times. The inspectors carried out the inspection primarily from a sun room located in the designated centre. From here, the inspectors were able to observe much of the daily activity in the centre. The inspectors ensured physical distancing measures and the use of personal protective equipment (PPE) were implemented during interactions with residents, staff and management over the course of this inspection.

From what residents communicated with the inspectors and what was observed, it was evident that the residents received a good quality of care in the designated centre.

Residents moved into the centre in 2018 from a campus based setting and staff reported increased well-being as a result of this move. This was particularly the case for one resident whose overall mental health and well-being had improved significantly, resulting in a reduced need for behavioural support. The centre is a modern bungalow which comprises of four bedrooms, a bathroom, shower room, kitchen/dining area, sitting room, sun room/office space/visitor's room and utility room. It is a short walk outside the local village. The inspectors observed a well maintained accessible garden to the rear of the house with a gazebo area and wind chimes and windmills set up which one resident was observed to enjoy.

On arrival to the centre, inspectors were greeted by two of the residents. The other residents were seated at the kitchen table enjoying their breakfast. All of the residents presented with complex communication needs and required staff to adapt their communication in order to best support them. One resident joined the inspectors in the sun room for some time in the morning and appeared to enjoy this. He showed inspectors his electronic tablet and was noted to enjoy the music. He also enjoyed the sound of a newspaper to his ear and came in and out of the room as the day progressed. Another resident was observed to relax on their bean bag intermittently and go out into the garden. Another resident went for a short walk. There were a range of sensory-based activities which staff had gathered (e.g. textures placed on soft tiles, noisy items) and these were offered to residents throughout the day. There was a desk set up for a resident to look at their newspaper and enjoy colouring. When staff were preparing the lunch, they were observed to cut and adapt food consistency at the kitchen table with residents.

Staff were observed as being very responsive to residents and interpreting their communication throughout the day. For example, one resident was observed to become vocal in the kitchen. A staff member supported them to go into the sitting room and offered them a hand massage which they refused. The staff then put on calm music to which the resident immediately smiled and sat down. All of the interactions were caring and supportive and person-centred. It was evident that

staff and residents were comfortable in each others company and this created a warm and homely atmosphere in the centre.

In the afternoon, two of the residents planned on going down to the local bakery to get some cakes while another attended an art class in a day service nearby. The house was busy planning for a birthday over the weekend. Overall, residents were observed to be very well cared for and content in their home. They were well supported by a staff team who were tuned into their communication, and as a result of this, able to meet their needs as they arose.

In summary, based on what residents communicated with the inspectors and what was observed, it was evident that residents received a good quality of care. However, there are some areas for improvement including polices and procedures, governance and management and residents finances. 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

Overall, the inspectors found that the registered provider and person in charge were striving to ensure a good quality and safe service for residents. There was a clearly defined management system in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge also had responsibility for two other designated centres and was supported in their role by a team leader. The person in charge demonstrated a clear knowledge of all of the residents and their assessed needs. It was evident from their interactions with residents that they knew them very well.

There was evidence of regular quality assurance audits taking place to ensure the service provided was effectively monitored. The provider had carried out an annual review of the centre. While this had clear actions and time frames, the annual review did not demonstrate consultation with residents and family, as required by the regulations. The six monthly unannounced visits had taken place. However, some improvement was required in the timeliness of the unannounced visits as there was a gap of eight months in between the last two. Each staff member in the centre had duties delegated to them by the person in charge such as health and safety, keeping a maintenance log and auditing activity planners and personal plans.

The previous inspection identified that arrangements for staffing required review. The registered provider had reviewed and increased the staffing levels in the centre. There were now three staff on duty by day in order to meet the residents' assessed needs, which staff reported to be hugely beneficial to enable them to give residents more time. The person in charge maintained planned and actual rosters. The inspectors reviewed a sample of staff rosters which demonstrated that there was an established staff team and a regular relief panel in place which ensured continuity of

care and support to residents.

Staff training in all mandatory and required areas specific to the centre was up to date. This included the management of epilepsy, first aid, food safety, medication management, fire safety and safeguarding. There was a clear record kept of when staff required an update in training. All staff had supervision , or "quality conversations", with the person in charge every twelve weeks. These conversations highlighted the role of each staff member in order to help improve the quality of life of people living in the centre.

The provider had prepared written policies and procedure in the matters as set out in Schedule 5 of the regulations. The previous inspection identified that improvement was required in ensuring the policies and procedures had been reviewed in a period not exceeded three years. The review of policies ensures staff are aware of best practice in their support of residents. While there was evidence of the establishment of working groups and the review of policies, a number of policies required review such as the residents' finance policy.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced. The person in charge worked in a full-time role and demonstrated a good understanding of residents and their needs.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. There was sufficient staffing levels and skill-mix to meet the residents' assessed needs. There was an established staff team and relief panel in place which ensured continuity of care and support to residents.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place to monitor staff training and development. The staff team were up-to-date in mandatory training including medication management, fire safety, safeguarding, dysphagia management, epilepsy and food safety. All staff had supervision, or "quality conversations" with the person in charge every twelve

weeks. These conversations highlighted the role of each staff member in order to help improve the quality of life of people living in the centre. The person in charge received supervision from their line manager once a month. In addition , there was an on-the-job training tool which was used to support staff in areas such as the development of positive risk taking within the service. Staff reported that they felt well supported in their roles.

Judgment: Compliant

Regulation 19: Directory of residents

The provider maintained a directory of residents which contained the information as required by Regulation 19.

Judgment: Compliant

Regulation 22: Insurance

The provider had ensured that the designated centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

There was a defined governance structure in place. The provider had carried out regular quality assurance audits including an annual review of the care and support in the centre. However the annual review did not demonstrate consultation with residents and family. In addition, the six monthly unannounced visits had taken place. However, some improvement was required in the timeliness of the unannounced visits as there was a gap of eight months in between the last two.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which was up to date, accurately described the service provided and contained all of the information as required by

Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and accidents occurring in the centre were appropriately notified to the Chief Inspector as required by Regulation 31.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had prepared written policies and procedures in the matters as set out in Schedule 5 of the regulations. However, a number of policies were not reviewed within the last three years. For example, the resident finance policy and the staff training and development policy.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that this centre was a comfortable home in keeping with the ethos of the provider. Management systems in place ensured the service was effectively monitored and provided appropriate care and support to the residents. However, improvements were required in resident's finances.

The inspectors reviewed a sample of residents' personal files. Each resident had an up-to-date comprehensive assessment which identified the residents' health, social and personal needs. The assessment informed the residents' personal plans which were up to date and suitably guided the staff team in supporting residents with identified needs. The previous inspection identified that improvement was required in residents' personal goals. This had been addressed. Residents had clearly identified person-centred goals and there was evidence of regular review and progression in achieving residents goals. Residents were supported to manage their own health and had to access health and social care professionals as required.

There were systems in place to safeguard residents. All staff had received training in safeguarding and protection of vulnerable adults. The inspectors reviewed a sample of incidents and accidents and found that they were appropriately reviewed and

responded to. Residents appeared content and relaxed in their home.

Improvements were required in the systems in place to manage residents finances to ensure that resident's were supported to manage their own financial affairs. In reviewing residents' finances, it was not evident that finance and capacity assessments were in place. The inspectors found that residents' had their own account managed for them by the provider. Staff then supported residents to access funds from this account and this money was managed at centre level by staff. This had been identified as an area of improvement and the person in charge informed inspectors that the provider was in the process of engaging with local financial institutions regarding setting up personal accounts for residents. In addition, on the day of the inspection, the inspectors viewed a sample of financial records and found that some improvement was required in the finance policy to guide staff in the record keeping of residents' finances.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents, if required. There was infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment (PPE), including hand sanitisers and masks, were available and were observed in use in the centre on the day of the inspection. The centre had access to support from Public Health.

Regulation 10: Communication

All residents had Speech and Language Therapy assessments in place. They had communication passports, plans and personal communication dictionaries in place. The personal communication dictionaries gave staff details on how the person communicated and how best to interpret and respond to that communication. Residents meetings took place using a Total Communication Approach to best support residents to understand the information and this was clearly documented in the minutes. Throughout the day inspectors observed staff responding to residents communication. They were very knowledgeable about how best to support and interpret each residents communication.

Judgment: Compliant

Regulation 12: Personal possessions

There were systems in place to manage residents finances. However, improvement was required to ensure that residents were supported to manage their own financial affairs. For example, it was not evident that finance and capacity assessments were

in place. From a review of a sample of financial records, some improvement was required in the finance policy to guide staff in the record keeping of residents' finances.

Judgment: Not compliant

Regulation 13: General welfare and development

Residents were able to access a day services hub in line with their identified needs and personal goals. Many of the residents responded best to activities using a multi-sensory approach (e.g. with cooking, residents touching, smelling and tasting foods). Staff had made tiles with a range of different materials on them for a resident to explore. On the day of inspection, residents were noted to go for walks, enjoy the chimes in the garden with a staff member, do art, listen to music and engage with staff. A resident went to an art class for the afternoon while two more residents were planning on visiting the local bakery to purchase some cakes. Inspectors reviewed daily and weekly planners and these were linked into residents personal plans. Staff had made great efforts to enable residents maintain contact with families through use of video calls during the COVID-19 pandemic.

Judgment: Compliant

Regulation 17: Premises

The centre was warm, homely and well suited to the needs of the residents. There was adequate space for residents, both in their bedrooms and in the communal spaces. There were suitable arrangements in place for the disposal of clinical and general waste. The house and garden was accessible and designed in line with the residents' preferences.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. Risks were managed and reviewed through a centre specific risk register and individual risk assessments. The risk register outlined the controls in place to mitigate the risks.Staff were knowledgeable about risks within the centre, particularly those relating to residents and measures to

mitigate these.

The centres vehicle was roadworthy, insured and regularly serviced. Staff did a weekly visual check of the vehicle and followed up on any identified issues as appropriate.

Judgment: Compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for COVID-19 in relation to staffing and the self-isolation of residents. There was infection control guidance and protocols in place in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. There was evidence of regular fire evacuation drills taking place and up-to-date personal evacuation plans in place which outlined how to support residents to safely evacuate in the event of a fire.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place for each resident. These were reviewed each month and an annual 'Visioning' meeting was held with the resident. Residents had clearly identified roles which informed their goals. There were activity planners on file which were directly linked with their goals. All residents had an electronic tablet which had photographs of them doing different activities to progress and achieve their goals. While this had been a challenge during the COVID-19 pandemic, staff had made adaptations in-house in order to best support the residents.

Inspectors saw photo based presentations which residents had used at their visioning meeting. Staff were knowledgeable about residents goals and how best to support choice making and goal setting with the residents, all of whom presented

with complex communication needs.

Judgment: Compliant

Regulation 6: Health care

The health-care needs of residents were suitably identified. Healthcare plans outlined supports provided to residents to experience the best possible health. Residents were facilitated to attend appointments with health and social care professionals as required.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in place to safeguard residents. All staff had received training in safeguarding and protection of vulnerable adults. Residents appeared content and relaxed in their home during the inspection.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ardeevin OSV-0005777

Inspection ID: MON-0033346

Date of inspection: 09/07/2021

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: SPC acknowledges the gap of eight months in completing the previous unannounced visits to Ardeevin. A schedule for completion of annual and 6 monthly unannounced visits is in place to ensure auditors are assigned for completion of visits. SPC has updated the recently developed template for annual unannounced reviews on the 05/07/2021 to ensure consultation with people supported and family members by including a section around "feedback from interactions with person supported and family members in the audit".	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: SPC has started a comprehensive review of old Schedule 5 policies in 2019/2020. Progression of this review had been delayed due to the outbreak of COVID-19 pandemic in March 2020. SPC policy working group is currently progressing with reviewing and updating relevant Schedule 5 policies as follows:- • A review meeting for the Missing Person Policy was held in May 2021 and final amendments to the policy will be agreed and discussed at the next meeting to on the	

12/08/2021.
• The drafted policy Managing People's Money and Property is currently under review by Finance and Quality Manager to necessary assessments and person centred planning is integrated in the procedures. The policy review will be finalised by 30/09/2021.
• SPC has adopted the HSE Food, Nutrition & Hydration Policy, a preamble has been added to the HSE document to acknowledge same. The policy will be signed off and rolled out in SPC as a Practice Development to all employees on 09/08/2021.
• HR is further progressing the review and updating of SPC Staff recruitment, selection and Garda Vetting Policy and have set a date for final sign off by latest 30/08/2021.
• The Health & Safety and also SPC staff training policy have been reviewed and updated by relevant department and will be circulated to Quality Assurance Group, SMT and Unions as per SPC Pathway on the 09/08/2021 for final review and signed off after completed review.
• The File retention policy is scheduled to be finalised by the 30/08/2021.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
As part of a full review of SPC Policy in relation to managing person's finances and property a new finance pathway has been implemented across the service as a practice development on the 23/06/2021.

SPC acknowledges that the inspector found additional improvements and guidance was required in relation to person's finances. SPC Finance and Quality Manager are currently developing the new policy, which will be based on a person centre approach, including the SPC Personal Planning Framework and also individual assessments for people supported.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/09/2021
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	05/07/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit	Substantially Compliant	Yellow	05/07/2021

	to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall 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.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	15/10/2021