

# eDeposit Ireland

## Idrone Lodge

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**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	Idrone Lodge
<b>Centre ID:</b>	OSV-0005515
<b>Centre county:</b>	Carlow
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	St Patricks Centre (Kilkenny) Ltd
<b>Provider Nominee:</b>	David Kieran
<b>Lead inspector:</b>	Ann-Marie O'Neill
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	0
<b>Number of vacancies on the date of inspection:</b>	4

## 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 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
18 August 2016 09:50	18 August 2016 18:30
19 August 2016 09:45	19 August 2016 18:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

Background to inspection:

This was an announced registration inspection. The registration inspection was taken on foot of an application to register by St. Patrick's Kilkenny Ltd Company. The provider had applied to register this centre as part of an overall de-congregation plan for the St. Patrick's Kilkenny campus.

This inspection gathered evidence to assess the fitness of the provider, St. Patrick's Kilkenny Ltd. to provide safe and appropriate supports to residents in line with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons

(Children and Adults) with Disabilities) Regulations 2013. The provider had applied to register the centre to accommodate four residents.

How we gathered evidence:

The inspector met with four residents, staff, the person in charge, provider nominee, team leader, quality, standards and compliance co-ordinator and practice development manager over the course of the inspection.

Policies and documents were reviewed as part of the process including a sample of health and social care plans, complaints management systems, contracts of care and risk assessments.

While the designated centre was unoccupied at the time of inspection, residents visited the centre on the first day of inspection to meet the inspector. The inspector observed staff interactions with residents in their proposed new home. Residents had varying communication abilities and the inspector interacted with residents in line with their communication styles and preferences as set out in their personal communication plans and following guidance from staff. Staff interaction with residents was observed to be pleasant, supportive and caring during their visit to the centre.

Description of the service:

The statement of purpose for the centre was not accurate and set out the mission statement, aims and purpose of another organisation. This required amendment.

The centre comprised of one large purpose built detached house, referred to in the report as the designated centre. They were located in a housing estate in the suburbs of a town in County Carlow. The provider had ensured residents would have access to a range of local amenities such as shops, churches, restaurants, pubs, barbers, hairdressers. The centre could accommodate four adult residents with varying degrees of intellectual disability and specific support needs in the management of healthcare and nutritional management, epilepsy and behaviours that challenge.

Overall judgment of our findings:

The inspector found overall the provider had put in place good systems to ensure the care and welfare of residents was met to a good standard. A significant amount of work had been implemented with regards to transition planning for residents identified to move into the centre. A full suite of assessments of needs for residents had been undertaken. To support residents' identified needs staff proposed to work in the centre had participated in extensive training in areas such as social role valorization, medication management, administration of emergency medication for the management of epilepsy, risk assessment, management of dysphagia, food preparation, hygiene and safety, vulnerable adult safeguarding and fire safety.

While the inspector found the provider had implemented good systems to support residents the arrangements for the role of person in charge required review. It was described that the person in charge would not be full-time in the role and have a range of other responsibilities outside the centre.

Overall 14 outcomes were found to be compliant or substantially compliant. Improvements were required in four outcomes where moderate non-compliance was identified.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end

**Section 41(1)(c) of the Health Act 2007. 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.**

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The inspector found evidence that residents moving into the centre would have their rights, privacy and dignity promoted and their personal choices supported and encouraged. Some improvements were required. The procedure for night time checks on residents required review to ensure residents' privacy was not impacted upon. The provider was also required to review systems in the centre to ensure residents could freely move about and access spaces in their intended home.

The inspector reviewed the complaints policy and found that it met the requirements of the Regulations. In addition the complaints procedure was located in a prominent position and in an easy read format in the centre. The complaints procedure identified who the complaints officer was for the organisation. However, it did not identify who the person nominated to manage complaints in the centre was.

The inspector reviewed a complaints log template that would be used to document complaints should one be logged by the resident or their representative and saw that it contained adequate detail with regard to recording a complaint, the investigation process carried out, the actions required to address the complaint and the complainant's satisfaction regarding the outcome of the complaint.

Residents would have access to independent advocacy services when they moved into the centre. Information and contact details were available in the centre.

The organisation had a managing people's money and property policy dated September 2015. All staff had been made aware of the policy and had signed they had read it. All

four residents intending to move into the centre required full support in managing their personal finances. The practice development manager, whose role has been to develop a comprehensive transition package for residents moving to the centre, outlined to the inspector processes that were intended to be implemented to support residents to manage their finances.

All residents would have a financial profile developed. Financial ledgers, with documented monetary in and out balances would be maintained and receipts for purchases and bank withdrawals and deposits would also be maintained in each residents' financial ledger.

Residents' monies would be transferred into a centre specific bank account and each resident's individual monies in the account would have their personal identification detailed in the account. Staff would withdraw or deposit money on behalf of residents in and out of the account. Where money was withdrawn each resident's financial ledger would be updated and a receipt maintained. The ledger would be used as part of financial auditing of residents' monies and the centre specific bank account.

The centre had adequate privacy options in place for the intended residents moving to the centre. All bedrooms, bathrooms and toilets had privacy locks. However, bedroom windows required improved privacy options where they could provide adequate lighting but ensured privacy from the outside. Some residents' bedrooms were located to the front of the premises and a nearby footpath. Residents intended to move to the centre could not independently maintain their privacy in their bedrooms and would require support from staff to maintain their privacy when using their bedrooms.

Staff spoken with during the course of the inspection informed the inspector of what their roles and responsibilities would be when residents moved into the centre. They informed the inspector that they would engage in one hourly night time checks of residents. While there was an identified risk for one resident at night time related to seizure related risks, there was no rationale for one hourly checks at night time for other residents. The person in charge was required to review this process to ensure it was based on identified risk otherwise one hourly checks on healthy residents could pose an invasion of residents' privacy.

During the inspection residents intending to move to the centre visited and spent a period of time there. During their visit to the centre the inspector observed residents were very settled and content. The inspector observed one resident spontaneously laugh, hum to herself and smile as she entered the living room space of the centre. Other residents chose to sit in the garden with staff while others lay on a couch in the living room and relaxed there for most of the time.

The inspector however, observed residents were unable to access many parts of the centre without the support of staff as they could not push open the heavy set fire doors in the centre. While the doors provided robust fire and smoke containment measures, the provider was required to ensure residents had free movement and accessibility in their home without restriction while ensuring appropriate fire safety compliance.

As part of residents' transition to the centre, activity sampling had been carried out to identify residents' interests and capabilities with a view to developing person centred plans for residents based on the social role valorization model of assessment. There were also areas designated within the centre that could provide residents with opportunities for meaningful engagement within their home on their terms. For example, the team leader for the centre showed the inspector a room which would be a designated art and hobby space, another room was also identified as a space for a relaxation room.

**Judgment:**

Non Compliant - Moderate

**Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**

Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

There was evidence to indicate the intended residents' communication needs would be supported in accordance with their assessed needs and preferences. There was a policy on communication in place to guide staff practice and procedures.

Residents' communication needs had been identified in their personal planning documentation and the supports they required would be put in place where needed. Each resident had a communication passport developed as part of their transition planning which contained detailed person centred information such as 'all about me', 'likes and dislikes' and 'how I communicate', for example.

Information in the centre was available in an easy to read format. If supports were required residents could avail of the services of a speech and language therapist (SALT) through local primary/community health care services.

Internet access was available in the centre as were radios and a television.

As part of the transition process, staff that knew residents from having worked with them previously in St. Patrick's Centre would move with residents to the centre. The inspector observed instances where familiar staff told other staff members, not familiar with residents' communication styles, what residents were communicating. For example, one staff member described, on behalf of a resident, how they liked to drink their tea and how to tell if the resident enjoyed it by the sounds and gestures they made.

Some residents intending to move to the centre had impaired vision. A review of residents' environment was required to ensure it could meet the needs of those with visual impairment and promote their independence and accessibility as much as possible.

**Judgment:**  
Substantially Compliant

**Outcome 03: Family and personal relationships and links with the community**

*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**  
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

The information made available to the inspector indicated residents' family, friends and representatives would be involved in included in decisions, planning and goals set for each resident. The centre would operate an open visitors' policy in line with policies and procedures for visits.

Staff would facilitate residents to maintain contact with their families. This included access to phone facilities, transport home if needed and an open visiting policy to the centre.

During the inspection the inspector spoke with the Practice Development Manager who had been involved in drawing up the transition process for each resident. Each resident's family had been included as much as possible in the decision making process and transition planning as much as possible. These discussions and decisions were made in line with families' wishes and respected the level in which family members wished to be involved.

Some resident's families had visited the centre. An open invitation to visit the centre had been made to all families. There was a policy on visitors available and there was a sign in book for visitors in the house which was up-to-date.

There was sufficient space available in the house to facilitate a resident to receive visitors in private if and when they wished.

The location of the centre was in close proximity to the local town. There were facilities in the locality residents could access and frequent which would ensure they had a presence in their local community and an opportunity to expand their connection and presence in their local community.

The inspector was also informed that a seven seat transport vehicle would be allocated solely for use by residents moving into the centre. This would ensure residents could access their community and go on visits when they wished.

**Judgment:**  
Compliant

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

There were policies and procedures in place to guide the admissions process. However, while transition planning was robust, person centred and inclusive residents did not have a contract of care in place which set out clearly the services they would be provided and the fees they would be expected to pay when they moved into the centre.

A centre specific contract of care that met the requirements of the regulations was required for residents intending to move into the centre.

**Judgment:**  
Non Compliant - Moderate

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

Systems were in place to ensure residents would have their social care needs met through the implementation of a comprehensive assessment of needs and person centre planning for residents. This would identify their personal goals and associated action plans would be developed to support residents to achieve their goals.

A sample of residents' personal plans was reviewed by the inspector. A comprehensive assessment of residents' social care needs had been carried out. Where a need had been identified, for example, epilepsy management, an associated support plan had been developed to direct staff in how to implement that resident's support needs, such as supervision level resident requires and medication the resident is prescribed.

Each resident would have a personal plan and a medical file amalgamated into one file to be known as the Personal Plan. Daily records would also to be maintained of the how the resident spent their day.

In St. Patrick's Centre Kilkenny a new transition team has been developed to support transitioning of residents from the congregated institutional campus to community residential settings. This team consists of one Practice Development Manager and four Community Transition Co-ordinators. The four Community Transition Co-ordinators are responsible for working with each individual re their social care needs and where appropriate, identify supports for the development of life skills, required for the living arrangements as have been identified with the individual residents.

Each resident identified to move into the centre had been afforded a comprehensive transition planning assessment to ensure their transition to the centre would be as much in line with their personal, individual needs as possible. Residents' representatives had also been involved in the transition process as much as possible.

All residents had been allocated a key worker and associate key worker prior to the inspection. The system for review of residents' identified social care needs had not been established yet.

**Judgment:**

Compliant

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The centre was suitable and safe for the proposed number of residents the provider had applied to register the centre for. Overall the inspector found the centre was homely and well maintained.

Each resident admitted to the centre would have their own bedroom. There were adequate bathing/showering and toileting facilities in the centre. All of which were of a modern standard. The inspector viewed bedrooms intended residents would move into. The inspector was informed that residents could decorate their bedroom how they wished when they moved in. Each bedroom had suitable storage options and adequate lighting and space for residents to mobilise safely.

The centre had a well equipped and spacious kitchen-dining room. There were two pleasant living room spaces which residents could use for relaxing or entertaining family members and friends if they so wished.

Laundry facilities were available in a utility space which was off the kitchen and the team leader for the centre informed the inspector residents would be encouraged and supported to attend to their own laundry. There were also plans to install a washing line to the rear of the centre which could also be used by residents.

A room was set aside for a staff office. All files, important documentation could be securely stored there.

There was a large well maintained garden area to the rear of the house. At the time of inspection the garden was supplied with wooden furniture where residents could sit.

There was adequate parking available to the front of the centre and the inspector observed that suitable arrangements were in place for the safe disposal of general waste.

**Judgment:**

Compliant

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The health and safety of residents, visitors and staff would be promoted in the centre. Fire containment and management procedures were in place and would be regularly reviewed. Infection control measures in place would meet the needs of residents and suit the purpose and function of the centre. Some personal risks for residents required more robust control measures in place.

The risk management policy was under review with final amendments to be made. Overall the policy met the matters set out in Regulation 26 including identification and management of risks, the measures in place to control identified risks and arrangements for identification, recording, investigation and learning from serious incidents. It did not include the matters as set out in Regulation 26 (e), arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Personal risks for residents had been identified and risk assessments were maintained in their personal plans. The inspector reviewed a sample of personal risk assessments. There were some improvements required to ensure risk control measures identified in personal risk assessments adequately managed the risk identified. For example, residents that could experience seizures associated with epilepsy required more robust control measures in place to ensure they were adequately monitored but also their privacy and dignity could be maintained.

At the time of inspection the control measure in place for management of a resident's epilepsy was one hourly checks by staff at night. However, the resident could stop breathing during seizure activity. The control measure of one hourly checks would not adequately mitigate the risk to the resident as a seizure could occur between checks. More robust control measures were required that would address the identified risk to the resident.

Fire safety and management policies and procedures were in place and centre specific procedures had been drafted. Fire evacuation notices and fire plans were displayed in the centre.

Regular fire drills would take place once a month. A record of the drill would be maintained. Individual personal evacuation management plans were documented for residents and would be updated as required. A fire safety register with details of all services and tests to be maintained was located in the centre. The inspector noted all fire extinguishers had received an up-to-date service July 2016. The fire alarm had also been serviced June 2016.

Fire exit doors were fitted with an electronic security fob system in addition to emergency measure push release mechanisms beside each exit door located next to the doors.

The inspector noted the presence of smoke seals on all doors in the centre. All doors in the premises also appeared to be heavy set fire compliant doors. This promoted good fire containment measures in the residential unit.

There was a policy on infection control available. Cleaning schedules had been drafted and cleaning of the centre would be completed by staff on an on-going basis. Hand washing and drying facilities in the centre were adequate to promote good hand hygiene in the centre. Colour coded mops and buckets were designated to clean specific areas in the centre to prevent cross contamination of surfaces.

Safe and appropriate practices in relation to manual handling were in place. All staff had attended up-to-date training.

**Judgment:**

Substantially Compliant

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The inspector was satisfied that adequate systems would be put in place to guide staff in how to respond to allegations or suspicions of abuse. Some improvements were required in relation to intimate care planning for residents. Behaviour support planning for residents also required improvement.

There were appropriate measures in place to protect residents being from being abused, measures in place also ensured staff working in the centre understood appropriate procedures for the response to allegations of abuse and detection of signs of abuse. Actions from the previous inspection had been addressed adequately.

There was a policy in place on the prevention, detection and response to abuse and all staff had received training. Staff spoken with and the person in charge outlined the procedures they would follow should there be an allegation of abuse. The provider had adopted the National Safeguarding Vulnerable Adults policy and procedures of which were in operation in the greater organisation. The policy and procedures would also be implemented in the designated centre when residents moved in.

Residents who could display behaviours that challenge had behaviour support plans in place where necessary. However, they were not adequate. Possible triggers which could

cause behaviours that challenge occurring were identified in behaviour support plans, however, there were inadequate guidelines to inform staff of ways in which to prevent behaviours that challenge from occurring or to guide staff in how to respond to them if they did.

For example, behaviour support plans did not outline the supports or interventions staff were required to implement should a resident engage in self injurious behaviour. Overall, the same approach was indicated for all behaviours displayed by residents. This was not in keeping with a person centred approach to behaviour support planning.

A restraint free environment was promoted in general throughout the centre. The inspector makes reference to the inability of residents to open doors in the centre due to their weight in Outcome 1 of this report.

Some residents were prescribed PRN (as required) chemical restraint medication for the management and response to behaviours that challenge. However, there was no reference to the use of chemical restraint in residents' behaviour support plans. Equally there was no protocol or criteria set out for its usage. Therefore it was not clear when the medication should be administered and what criteria were in place to ensure its use was in line with strict guidance, adherence to best practice and as a last resort.

Intimate care planning was in place for residents and maintained in their personal plans. Some improvements were required however, to ensure intimate care planning was specific and personal to residents. The inspector reviewed a sample of intimate care plans and found while they identified some levels of independence residents had they were not specific enough to ensure residents personal preferences were detailed.

For example, they did not outline residents preferences with regards to water temperature they preferred, products residents liked to use and their levels of independence in all aspects of intimate care. Some details documented in residents intimate care planning would not ensure appropriate measures in place to maintain their privacy and dignity. For example, one intimate care plan recommended 'the door to be kept slightly ajar' when supporting the resident with intimate care.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The person in charge and provider nominee were aware of their legal requirement to notify the Chief Inspector regarding any incidents and/or accidents occurring to residents living in the centre.

**Judgment:**

Compliant

**Outcome 10. General Welfare and Development**

*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**

Health and Development

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

The residents' move to the centre would greatly improve their overall quality of life. Their move from an institutional congregated setting to a community residential service would provide them with greater opportunities for engagement with their local community and opportunities to participate as full citizens within that community.

The inspector was assured that when the plans discussed were implemented, the general welfare and development needs of resident living in the centre would be promoted. Evidence available during the inspection indicated residents would be afforded opportunities for new experiences, social participation and gaining new life skills.

A life skills and goals assessment would be carried out with residents as part of their transition process and from the assessment appropriate skill teaching opportunities would be identified for each resident. This would promote residents' independent living skills as much as possible. For example, they intended to support the residents to learn how to participate in cooking meals and making snacks in the centre. Also, doing their laundry and the general upkeep of the centre.

**Judgment:**

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):**

This was the centre's first inspection by the Authority.

**Findings:**

There was evidence to indicate that residents' healthcare needs would be adequately assessed and regularly reviewed with appropriate input from allied health professionals where and when required.

The team leader informed the inspector that each resident moving to the centre would have access to a general practitioner (GP) locally. The team leader had made provisions for residents' health and medical files to be transferred to the GP. The GP was located in a local primary healthcare practice and residents would have access to the services of the community primary healthcare team.

All residents intending to move to the centre had received an up-to-date health check. Some health care needs for each resident had been identified with associated healthcare plans in place to guide staff in how to support the resident. Some epilepsy management risk management planning required more robust systems in place, this is further discussed in Outcome 7; Health and Safety and Risk Management.

There was a large kitchen in the centre which was adequately supplied with appliances and space to prepare home cooked meals. Residents' nutritional needs had already been assessed and would meet residents' needs to an appropriate standard when implemented.

Staff intending to work in the centre had received training in dysphagia management, first aid, food safety and hygiene. They were also scheduled to undergo food preparation training to ensure they had the skills to prepare modified consistency meals for residents.

**Judgment:**

Compliant

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

**Findings:**

The proposed medication management policies and procedures for the centre were found to be appropriate and in line with the regulations.

The centre had a medication management policy in place. The aim of the policy was to ensure the safe administration and management of medication for all individuals living in the centre. The inspector reviewed the policy which was comprehensive and gave guidance to staff on areas such as medication administration, medications requiring strict controls, ordering, dispensing, storage, administration and disposal of medications. The policy was also informative on how to manage medication errors.

From a sample of files viewed the inspector saw that all staff identified to work in the centre had undertaken a medication management training programme which included competency assessments.

Safe storage facilities were provided in the centre. Residents' medication would be stored in a locked press in a designated area which could only be accessed by staff using a key.

Audits would also be undertaken to ensure compliance with the centre's policy and that all required documentation is correctly completed and up to date.

The team leader had established links with the local pharmacy prior to the intended resident moving to the centre. A pre-packed medication dosage system would be used. Each resident's medications would be dispensed to the centre in a pre-packed individualised dosage system from which staff would administer medication.

**Judgment:**

Compliant

**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:**

The statement of purpose consisted of a statement of aims and objectives of the centre and a statement as to the facilities and services which were to be provided to residents. However, some changes were required.

The aims, objectives and mission statement as set out in the statement of purpose did not reflect those of St. Patrick's Kilkenny and were relevant to another organisation.

**Judgment:**

Substantially 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):**

This was the centre's first inspection by the Authority.

**Findings:**

Overall, there were adequate systems in place to ensure effective governance and management of the centre. There were some improvements required to ensure the role of the person in charge would be full time to ensure there would be effective oversight and governance of the centre. The provider had not ensured the person in charge would be in their role in a full-time capacity and have adequate supports in place to fulfil the role.

St Patrick's Kilkenny Ltd is a registered company. The service is funded by the Health Service Executive with whom it has a service level agreement which is reviewed annually. St. Patrick's Kilkenny Ltd is managed by a Voluntary Board of Management. The Board of Management for the Company had changed in February 2016. The Health Information and Quality Authority (HIQA) received notification of this change.

The provider nominee reports to the Board regularly through formalised meetings at least monthly. Some of the items they report to the board include an overview of accidents and incidents in the designated centres of the service. Other items discussed are resourcing, budgets, staff recruitments, investigations into alleged abuse and updates on HIQA inspections.

There would be a clearly defined management structure for the centre and a robust governance system with the lines of responsibility and accountability set out. The management team for the centre would consist of the provider nominee, the director of services, the person in charge and a person participating in management directly in the centre a CNM1 (Clinical Nurse Manager).

The inspector met the proposed person in charge during the inspection. The person in charge had worked in disability services for many years and in total had worked for St. Patrick's Kilkenny Ltd for approximately 15 years. The person in charge is a qualified intellectual disability nurse.

He was also delegated responsibility within the organisation as assistant director of service for the wider congregated setting in St. Patrick's Kilkenny Ltd. He was also the designated officer and complaints officer for the organisation with a remit in training and a member of the human rights committee for review of restrictive practices in the organisation. At the time of inspection it was intended that the person in charge would keep those delegated roles as well as being the person in charge of the centre.

Given the multiple roles the identified person in charge would be delegated the provider did not demonstrate that the proposed arrangement for the role of person in charge would comply with the regulations. The provider had not ensured the person in charge would be in their role in a full-time capacity.

While the intended person in charge demonstrated knowledge and experience in the management of staff, abuse allegation investigations and management of complaints, they did not demonstrate adequate knowledge of their regulatory responsibilities as person in charge. The provider was required to ensure the person in charge identified for the centre was adequately informed and updated as to their regulatory roles and responsibilities.

The provider nominee met with the inspector and informed them that unannounced six monthly visits would be carried out. The visits would be carried out by the provider nominee, director of services and/or the quality standards and compliance co-ordinator. An annual review would be also be drafted which would incorporate the findings from the six monthly provider led audits. Copies of the annual report would be made available to residents and their families.

The inspector met with the quality, standards and compliance co-ordinator for the service. She outlined to the inspector the work she had implemented to bring about improvements in compliance and standards as part of the opening of the designated centre. Some examples included a full audit and review of residents' personal plans to ensure they contained the most up-to-date information for residents with regards to their healthcare and social care needs.

She had also devised a new personal plan format and had trained staff working in the centre how to implement the new support planning framework. They intended to spot check and audit residents' personal plans on an ongoing basis and provide support, guidance and training to staff and managers of the centre going forward.

**Judgment:**  
Non Compliant - Moderate

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

The provider nominee was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days.

The person participating in management (team leader) worked in the centre and was the person identified to assume responsibility of the centre in the absence of the person in charge.

**Judgment:**

Compliant

**Outcome 16: Use of Resources**

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**

Use of Resources

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

The centre was maintained to a good standard and was near ready for occupation. The centre had access to an on-call maintenance department which responded promptly to any maintenance issues in the centre.

There were resource issues within the organisation of St Patrick's Kilkenny, however the inspector was assured by the provider that these issues would not affect the residents intending to move into the centre.

**Judgment:**

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):**

This was the centre's first inspection by the Authority.

**Findings:**

Systems in place indicated that staff had been recruited, selected and vetted in accordance with best recruitment practice. There would be a full-time team leader in place to ensure staff were appropriately supervised.

The inspector reviewed a sample of staff files and saw that they met the requirements of the Regulations.

A sample roster was reviewed. This indicated there would be adequate numbers of staff allocated to support residents during the day with a waking staff compliment in the centre at night time. The provider nominee informed the inspector that the staffing ratio would be adjusted based on the needs of residents at any given time. The planned staffing arrangements were in line with the statement of purpose.

The practice development manager explained to the inspector the new roster system that would be implemented in the centre. It was called responsive rostering where staff would work shorter shifts. Rosters and allocated shifts for staff would be implemented to suit the needs of residents.

Staff identified to work in the centre had undergone a suite of training which would ensure they had the skills and knowledge to support residents and their specific identified needs.

Staff had attended training in areas such as the management of behaviour that challenge, safe administration of medication, manual handling and fire safety training, administration of emergency rescue medication, social role valorization, safeguarding vulnerable adults, basic life support and use of oxygen, food safety and hygiene and risk management.

The inspector spoke with three staff identified to work in the centre. They informed the inspector they had enjoyed the training they had received. They were also looking forward to working in the centre and were proud to have been selected from a recruitment process to work there. The inspector observed staff with residents on the first day of inspection and found their interactions with residents to be pleasant, patient and caring.

There were no plans in place at present to have volunteers in the centre. Should that change, the provider nominee was aware of the requirements of the Regulations in this regard.

Staff supervision would be ongoing with scheduled supervision and appraisals sessions once they started working in the centre.

**Judgment:**  
Compliant

**Outcome 18: Records and documentation**

*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**  
Use of Information

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

There were systems in place to maintain complete and accurate records in the centre. All schedule 5 policies were in place.

The designated centre had all the written operational policies required by Schedule 5 of the Regulations.

Up-to-date insurance cover was in place for the designated centre.

The residents' guide provided detail in relation to all of the required areas. The document included a summary of the services and facilities to be provided, arrangements for resident involvement in the centre and a summary of the complaints procedure.

There were systems were in place to ensure that medical records and other records, relating to residents and staff, would be maintained in a secure manner.

Although not yet required an appropriate template for the completion of the directory of residents in line with the Regulations was available.

<b>Judgment:</b> Compliant
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### **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

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Idrone Lodge
<b>Centre ID:</b>	OSV-0005515
<b>Date of Inspection:</b>	18 August 2016
<b>Date of response:</b>	27 September 2016

### 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 is failing to comply with a regulatory requirement in the following respect:**

The provider is required to ensure residents had free access and movement in their homes to ensure residents had choice and accessibility in their home without restrictions but also ensuring appropriate fire safety compliance.

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

**1. Action Required:**

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

**Please state the actions you have taken or are planning to take:**

All Doors now commissioned as accessible by residents.

**Proposed Timescale:** 08/11/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The person in charge was required to review the process of one hourly night time checks to ensure it was based on an identified risk requirement and did not impact on the privacy of residents.

Bedroom windows required improved privacy options where they could provide adequate lighting but ensured privacy from the outside.

**2. Action Required:**

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and 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:**

Risk assessments carried out and hourly night checks are inappropriate in this setting. This practice will not transfer to Idrone.

Appropriate window dressing are in situ.

**Proposed Timescale:** 08/11/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The complaints procedure for the centre did not identify who the person nominated to manage complaints in the centre was.

**3. 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:**

The Complaints policy has been amended to include reference to a locally nominated person who will manage complaints.

The Easy Read Complaints Policy and the Complaints Poster will reflect this also.

**Proposed Timescale:** 08/11/2016

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A review of residents' environment was required to ensure it could meet the needs of those with visual impairment and promote their independence and accessibility as much as possible

**4. Action Required:**

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

**Please state the actions you have taken or are planning to take:**

Eye Assessments have been completed for all Residents and outcomes have been recorded.

An appointment has been made with NCBI to assess the environment for one resident who is recognised as having a visual challenge.

Purchase of I-Pads has been approved – Model specifications being explored  
Communication IT Tablets – On receipt of SRF funding

**Proposed Timescale:** 08/11/2016

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A centre specific contract of care that met the requirements of the regulations was required for residents intending to move into the centre.

**5. Action Required:**

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details

of the services to be provided for that resident and where appropriate, the fees to be charged.

**Please state the actions you have taken or are planning to take:**

Contracts are in-situ and will issue on transition.

**Proposed Timescale:** 08/11/2016

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk policy did not include the matters as set out in Regulation 26 (e).

**6. Action Required:**

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

**Please state the actions you have taken or are planning to take:**

The Risk Policy will be reviewed to ensure minimal adverse impact on the resident's quality of life.

The Risk Policy has been amended to reflect supportive Risk Management.

**Proposed Timescale:** 08/11/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were some improvements required to ensure risk control measures identified in personal risk assessments adequately managed the risk identified.

**7. 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:**

Risk Register has been amended.

**Proposed Timescale:** 08/11/2016

## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents who could display behaviours that challenge had behaviour support plans in place where necessary. However, they did not provide an adequate level of detail and guidance.

**8. Action Required:**

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

**Please state the actions you have taken or are planning to take:**

Each individual will have an annual personal planning meeting with her representative where all therapeutic interventions are discussed and agreed upon.

All Behaviour Support Plans have been implemented.

**Proposed Timescale:** 08/11/2016

**Theme:** Safe Services

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

Some residents were prescribed PRN (as required) chemical restraint medication. It was not clear when the medication should be administered and what criteria were in place to ensure its use was in line with strict guidance, adherence to best practice and as a last resort.

**9. Action Required:**

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**

PRN Protocol have been implemented.

**Proposed Timescale:** 08/11/2016

**Theme:** Safe Services

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

Intimate care planning was in place for residents and maintained in their personal

plans. Some improvements were required however, to ensure intimate care planning was specific and personal to residents

**10. Action Required:**

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

**Please state the actions you have taken or are planning to take:**

Intimate Care Plans have been reviewed to reflect individuals' personal preferences.

**Proposed Timescale:** 08/11/2016

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The aims, objectives and mission statement as set out in the statement of purpose did not reflect those of St. Patrick's Kilkenny and were relevant to another organisation.

**11. Action Required:**

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

**Please state the actions you have taken or are planning to take:**

Statement of Purpose and Mission Statement has been amended to reflect the organisations, Vision, Beliefs and Values.

**Proposed Timescale:** 08/11/2016

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The provider had not ensured the person in charge would be in their role in a full-time capacity.

The provider had not ensured that the person in charge identified for the centre had knowledge of their regulatory roles and responsibilities.

**12. Action Required:**

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

**Please state the actions you have taken or are planning to take:**

A CNM1 on the staff team meets all requirements as per Regulation 14 (2) requirement for the PIC role.

The formal process of registering the CNM1 as PIC has commenced.

**Proposed Timescale:** 09/11/2016