### Health Information and Quality Authority
#### Compliance Monitoring Inspection report
#### Designated Centres under Health Act 2007, as amended

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Idrone Lodge</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0005515</td>
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<td>Centre county:</td>
<td>Carlow</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Saint Patricks Centre (Kilkenny)</td>
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<tr>
<td>Provider Nominee:</td>
<td>David Kieran</td>
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<tr>
<td>Lead inspector:</td>
<td>Ann-Marie O'Neill</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>4</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

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

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<tr>
<td>07 September 2017 10:00</td>
<td>07 September 2017 16:30</td>
</tr>
<tr>
<td>08 September 2017 10:00</td>
<td>08 September 2017 15:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 13: Statement of Purpose</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 15: Absence of the person in charge</td>
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<td>Outcome 16: Use of Resources</td>
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**Summary of findings from this inspection**

Background to Inspection.
This inspection was an unannounced monitoring inspection that took place over two days. The centre had previously been inspected as a ‘new build’ centre in April 2017 for the purposes of registering to allow four adult residents could move from St. Patrick’s Centre.

The purpose of this inspection was to inspect the progress of residents since they had moved to the designated centre and assess if the provider was meeting the needs of the residents to a good standard in compliance with the Regulations. All outcomes were reviewed during this inspection and actions from the previous
inspection followed-up on to ensure the provider had completed them in line with their action plan response and timelines that had been agreed.

How we Gathered Evidence.
As part of the inspection, the inspector met with the recently appointed person in charge of the designated centre, the director of services staff and four staff during the course of the inspection.

The inspector also met and spoke with all four residents in the centre during the two days of inspection. Residents’ specific communication repertoires meant they could not describe the service they were receiving. In light of this the inspector requested to speak to a family representative of a resident living in the. The inspector and representative had met on the previous inspection before the resident had moved into the centre. Their feedback was very positive and they felt the service was meeting the needs of their sibling in a more positive and holistic way and from a family's perspective the new environment was encouraging and supporting their relationship better. For example, the environment was more conducive for families to visit and spend time with their resident in their home.

The inspector at all times respected residents' personal choice to spend time with the inspector or not to during the inspection.

The inspector reviewed documentation such as risk assessments, behaviour support plans, personal plans, schedule 5 policies and systems in place to manage residents' personal finances such as financial ledgers and bank statements. The inspector also carried out an observational review of the premises both inside and out.

Description of the Service.
The centre comprises one detached house, referred to in the report as the designated centre. 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, nutrition, including specific dietary requirements, epilepsy and behaviours that challenge.

Overall Judgment of our Findings.
Significant tangible improvements had occurred. Residents were having increased regular experiences in their local community and were now becoming recognised and acknowledged as part of their local communities. Residents' family connections had been enhanced and residents and their families had celebrated a house warming occasion in their local hotel. Photographs of this occasion were maintained in the centre and showed residents dancing with their siblings and enjoying the meal and cake provided. Feedback from a resident's representative was that it was a very special occasion for them and they really enjoyed the occasion.

Residents’ nutrition had improved also. Some residents no longer required the quantity of nutritional supplementation they had been in receipt of previously and their medical practitioner had begun to reduce the number of supplements they
required due to them achieving a healthy body weight or showing evidence of gaining weight. This was a significant tangible improvement in the healthcare of residents and an indication that they were achieving their best possible health.

There were also other improvements.

Some residents now living in the centre had previously required safeguarding planning to protect and support them from peer-to-peer assaults and abuse when they lived in the campus of St. Patrick’s Centre, Kilkenny. These were no longer required. No such incident had occurred in the centre since their move and the risk of it occurring had reduced significantly. There were also low numbers of incidents of behaviours that challenge and where support planning was required the impact of the incidents had lessened considerably.

Some residents had begun to use more words and sentences to communicate their needs since moving to the centre. Residents that had previously found waiting difficult were beginning to demonstrate better coping skills for example. Speech and language communication assessments were underway which would help to support residents in enhancing these latent or emerging skills.

While these were significant improvements in residents’ overall quality of life some improvements were required in relation to residents’ access to advocacy, choice making and independence.

Improvements were also required in relation to staff training to ensure they had received training in specific areas to meet residents’ assessed needs. All schedule 5 policies required updating, review and revision in order to meet the regulations.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.
Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Residents living in the centre had their privacy and dignity supported to a good standard. Since moving to this centre residents were now experiencing greater freedoms and lessening of restrictions which they would have experienced in their previous living environment. Greater rights promotion was required. This related to documenting and recording of complaints, facilitation of advocacy and consultation and the provision of activities and hobbies for the residents to engage in whilst spending time in their home.

The complaints procedure was located in a prominent position in the centre and in an easy read format. The procedure was however, not up-to-date and did not identify who the current complaints officer was and the person nominated to manage complaints in the centre also. The inspector reviewed the complaints log for the centre. There were no active complaints under review at the time of inspection.

One complaint had been recorded which related to residents’ expenditures. The complaints log indicated the complaint had been resolved and was to the satisfaction of the complainant however, improvement was required. The recorded complaint did not give enough information as to the details of the complaint, it also did not outline in enough detail how the complaint was managed and while the log indicated the complainant was satisfied with how the complaint was managed this was indicated using a tick rather than the signature of the complainant or their sought feedback.

Improvement in the recording of complaints and the detailing the management of complaints was required to enable comprehensive auditing of complaints management in the centre to ensure it was in line with the organisation’s complaints policy and procedures. A more detailed description of the complaint in the complaints log was also
required to ensure complaints, which could constitute a safeguarding concern, for example could be identified through the auditing process.

The inspector reviewed a sample of resident meetings which had occurred, however they lacked recorded evidence of residents’ feedback or choices through that process. Improvement in gathering residents’ feedback and facilitation of choice was required. This was of particular importance in this centre given residents’ specific support needs with regards to communication.

Residents had access an independent advocate if and when they required. Information and contact details were available in the centre. While this was in place, residents did not have the capacity to independently request a visit or meeting with the advocate and the advocate had not visited the centre since it opened, to meet with residents. The provider was required to facilitate residents in developing a meaningful connection with their independent advocate in light of their specific support needs.

The centre had adequate privacy options in place for residents. Each resident had their own bedroom. Bedroom windows were fitted with blinds which provided residents with privacy arrangements while they engaged in personal activities in their bedrooms.

The organisation had a policy on personal property, personal finances and possessions which guided practice in the organisation with regards to these matters. All residents living in the centre required support in managing their personal finances. Each resident was issued with up-to-date bank statements which were maintained in their personal plan folders. An inventory of each resident’s personal property had been carried out and on this inspection was found to be detailed and up-to-date.

Activities available to residents were suited to their age and interests outside of the centre. Residents were supported to go on planned trips and excursions, shopping and attending activities available in St. Patrick’s Centre day services, for example. There was however, improvement required in relation to the personal interests and hobbies options for residents while they were at home.

The designated centre was large and accommodated rooms which were to be dedicated as a sensory room and an art and hobby room which the residents could use independently or with the support of staff during the day. However, on this inspection these spaces had not been fitted out to provide these activity options. The provider was required to address this to ensure residents were provided with opportunities for engagement both within and out of their home.

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):**
No actions were required from the previous inspection.

**Findings:**
Residents’ communication needs were supported in accordance with their assessed needs and preferences.

Residents’ communication needs had been identified in their personal planning documentation. Each resident had a communication passport setting out their individual communication styles.

Residents could avail of the services of a speech and language therapist (SALT). There was evidence that SALT assessments with regards to residents’ communication needs and interventions had begun.

Internet access was available in the centre as was a stereo and large flat screen television. Each resident also had their own Ipad which they used as part of an augmented communication system and contained photographs of their favourite meals, activities they had engaged in or places they had visited.

Staff working with residents knew residents very well and understood their individual communication repertoires.

**Judgment:**
Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
Residents’ lives had transformed in a positive and remarkable way since moving to their new home from the St. Patrick’s Centre congregated setting.

Residents currently living in this centre had previously lived in the congregated campus setting of St. Patrick’s Centre, Kilkenny. While living there some residents rarely left the campus grounds to experience the wider community they were part of.
The move to this designated centre had transformed residents’ lives in relation to their experiences of life in the community and repertoire of experiences.

Residents were now involved in going to the local shop to buy groceries and clothes. Local people in the community were now getting to know residents and recognised them in local shops, saluting them or saying hello when they met them, according to staff.

The inspector spoke with a family member of a resident that had moved to the centre. They informed the inspector that their sibling seemed very happy in their new home. They also told the inspector that they enjoyed spending time with their sibling in their new home.

The provider was required to continue improving residents’ lives in this way and afford them opportunities to take positive risks and experience community.

**Judgment:**
Compliant

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**Outcome 04: Admissions and Contract for the Provision of Services**
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

**Theme:**
Effective Services

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

**Findings:**
The inspector reviewed residents' contracts of care to ascertain if they had been signed or agreed with the resident and or a representative on their behalf acting in their best interests. It was noted that residents contracts were still being reviewed by their families and representatives and had not been signed at the time of inspection.

The provider was in an active consultation process with regards to the contracts for residents and their representatives and hoped to have a resolution.

Residents now had more disposable income from their disability allowance each week. Fees payable by residents had reduced due to their move to community residential setting which reflected the new long stay charges directive by the HSE. (Health Service Executive)

**Judgment:**
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):
No actions were required from the previous inspection.

Findings:
The care and support provided to residents was consistently and sufficiently assessed and reviewed. Personal plans reflected residents' assessed social care needs. While short term goals set had been achieved more work was required with regards to long term goals for residents.

The inspector reviewed a sample of personal plans which were found to be comprehensive and detailed and reflected residents' specific requirements in relation to their social care needs. Each personal plan provided evidence of comprehensive allied health professional review, assessment and recommendations on an ongoing basis. Some improvement was required in relation to goal setting, action planning and reviews.

There was evidence of assessment implemented and ongoing monitoring of residents' needs including residents’ interests, communication needs and daily living support assessments. Residents' assessment of needs included general likes and dislikes, nutrition, intimate care and personal hygiene, behaviour support planning and healthcare assessments.

Personal plans also contained information records such as personal risk assessments, support plans, daily reports, allied health professional recommendations and appointment updates.

While there was significant improvement in the level of assessment and detail with regards to residents' social care needs and allied health professionals' input, the flow of the personal planning was disjointed and still difficult to navigate. While all elements to meet compliance in this outcome were in place they were located across a number of folders. In order to find evidence that residents' assessed needs had an associated support plan in place it required a significant amount of time cross referencing through numerous folders to find them and link them together. This was not an effective system which could ensure all assessed needs had planning in place to support residents.
An improved approach to goal setting was required to ensure when a goal was identified an action plan was developed which set out the steps required to achieve the goal, evidenced inclusion of the resident in establishing those steps, who was responsible to complete each step and by what timeline.

**Judgment:**
Substantially Compliant

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**Outcome 06: Safe and suitable premises**

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

**Theme:**
Effective Services

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

**Findings:**
The previous inspection of this centre found compliance in this outcome. The provider had maintained the centre to a good standard of upkeep and cleanliness with systems in place to ensure this was maintained going forward.

Plans were in place to improve the personalisation and furnishing of residents bedrooms by supporting residents in the purchasing of curtains in line with their personal taste and decor of their respective bedrooms.

**Judgment:**
Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
The previous inspection report for this outcome found compliance and on this inspection there was evidence which indicated the provider was still implementing those systems. Some improvement was required in relation to recording of vehicle maintenance checks and servicing.

As found on the previous inspection the provider had ensured comprehensive fire safety and maintenance was in place. Fire safety equipment were serviced as required and safety checks were up-to-date. Residents had participated in fire evacuation drills and personal evacuation planning was updated following drills if and when required.

Risk management systems were also adequate and all residents' personal safety risks had been updated to reflect their new living arrangements. There was an overall reduction in the number of falls and accidents. The inspector reviewed the incident recording system in the centre which evidenced overall a low number of incidents which evidenced minimal risks to residents for those that had occurred.

Appropriate systems were also in place in relation to the management of infection control in the centre. Colour coded mops and buckets were in use and adequate hand hygiene systems were also in place.

The centre was resourced with its own transport vehicle. However, vehicle maintenance records maintained did not evidence that the vehicle had received a service or check following the identification of an issue. For example, in both July and August fault lights had appeared, however, there was no evidence maintained in the centre to indicate the vehicle had received a check or service in response to this.

**Judgment:**
Substantially Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
There were no actions from the previous inspection. However, on this inspection the inspector noted improvements were required in relation to systems for the detection and
prevention of financial abuse. Behaviour support planning for residents required some improvement to ensure plans reflected measures for staff to implement and support residents in their new home.

Staff informed the inspector that there had been a reduction in the number of challenging behaviour incidents since residents had moved to the centre. This was also evidenced through review of documented incidents in the centre and residents’ daily narrative notes.

Equally encouraging was the absence of to peer-to-peer incidents in the centre. This risk had been prevalent in residents’ previous living arrangements and had occurred on a regular basis. This further evidenced this new environment was meeting residents’ individual needs.

Some residents required behaviour support planning and management. While support planning was in place they were relevant to residents’ previous living arrangements and did not reflect their new living arrangement. Behaviour support planning for residents did not reflect the support requirements they needed for living in their new home.

Improvement was also required in relation to the auditing of residents' personal finances to consistently and effectively monitor for financial abuse. Each residents’ personal monies were managed using a financial ledger which logged when residents received money and when they spent money.

Receipts were obtained for each transaction and sent to the main office for auditing purposes but were not utilised at an operational level within the centre for regular auditing of transactions and as part of a financial abuse prevention system.

For example, in some ledgers reviewed during the inspection, balances documented did not tally up with monies actually contained in residents’ individual purses. Where this occurred there were no receipts available or other systems in place to support staff in ascertaining why there was a discrepancy, for example. Equally as staff did not audit residents’ personal financial ledgers within the centre this led to a risk of financial abuse or mismanagement going unidentified.

While the inspector did not find any grounds to indicate there had been any form of financial abuse in the centre at the time of inspection, the system for safeguarding residents from financial abuse required improvement in order to prevent it from occurring and ensure it would be detected it in a timely way.

**Judgment:**
Substantially Compliant

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

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

**Findings:**
No notifiable incidents had occurred in the centre since residents had moved in. The person in charge and persons participating in management of the centre on an ongoing basis demonstrated a good understanding of incidents that would require notifying and the timelines.

**Judgment:**
Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
Overall, residents general welfare and quality of life had improved significantly since moving to the centre.

This was evident in the reduced occurrence of behaviours that challenge incidents, the absence of peer-to-peer incidents and the emergency and improvement of some residents' personal skills.

For example, one resident had begun to use spoken words and short sentences since moving to the centre. Others had begun to demonstrate improved waiting skills, for example at mealtimes, which had previously been a difficult time for the resident eliciting in them distress and disruption for others sharing the environment.

However, assessments of residents needs did not include an assessment relating to employment and education skills in line with their abilities, interests and potential.

Given that residents now lived in a more optimum environment and were demonstrating emerging latent skills and abilities, their employment, occupation and educational skills could now be explored and assessed in a more meaningful way.
Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
Significant improvements in the overall medical and allied health professional assessment of residents' healthcare had occurred and were still ongoing. Such were the improvements in some residents' health their requirement for additional nutritional supplements had begun to reduce. Residents with specific dietary requirements were now eating meals similar to their peers and experiencing choices and tastes which they really appeared to enjoy.

As mentioned in previous inspection reports for St. Patrick's Centre, residents' access to and assessment by allied health professionals had improved significantly. Each resident was afforded a monthly allied health professional review whereby each resident's support needs were discussed and reviewed by the relevant allied health professionals associated with their care. This systematic and thorough review of each resident was reflecting positive and improved healthcare outcomes for residents.

By way of illustrating the significant improvement in residents’ welfare and health one example is set out below.

Due to the previous institutional meal provision in St. Patrick’s congregated setting whereby all residents’ main meals were prepared in the main kitchen and delivered to the centre, a resident with a dairy free dietary requirement was not individually catered for. Therefore the resident, most days ate mashed potato and mince only for their main meal. The resident was most days not offered an alternative or choice similar to their peers due to the institutional meal provision service on the campus.

The residents’ daily meal experience was overall devoid of different taste experiences and did not afford them equality with their peers in terms of food provision, enjoyment or experience.

On this inspection the inspector observed a different experience for the resident. They were observed to eat their meals with their peers in a pleasant, homely environment. The resident was also observed to eat their meal with cutlery and do so independently.
They were also now supported to purchase their own specific dairy products including condiments, sauces, cheeses and milks to meet their needs.

Since moving to the centre they had enjoyed eating Sheppard’s pie, homemade stews, and pasta bakes of different varieties, for example all prepared with consideration of their dietary requirements. The resident was now receiving nutritious food which was prepared with consideration and care, looked appetizing and was the same as their peers.

Staff took photographs of the meals prepared to aid in offering food choices to residents and residents engaged in food preparation and cooking which staff told the inspector they enjoyed.

Some residents, while residing in their previous living arrangement, had required additional nutritional supplements such as drinks and shakes to provide them with optimum nutrition and prevent weight loss, for example. Since their move to this centre the number of supplements prescribed them had begun to reduce due to their diet having improved.

This was a significant indicator that resident’s nutritional health was improving and the quality of nutrition they were receiving was meeting their individual needs.

Overall, there was clear and tangible evidence residents’ quality of life and health was improving since moving from the congregate setting.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
The inspector did not review this outcome in its entirety on this inspection as it had been found compliant on the previous inspection. The aspects reviewed on this inspection related to the implementation of systems for safe medication management in the centre at the time of inspection.
Safe and suitable storage space was in use in the centre at the time of inspection.

Staff spoken with were knowledgeable of appropriate and safe practices and described safe procedures to the inspector.

Only staff that had completed safe administration of medication training and competency assessments engaged in administration of medication in the centre. Most staff had also received training in the administration of oxygen and buccal midazolam (emergency medication for the management of seizures). Plans were underway to ensure all staff had received training in administration of medication.

Systems were also in place for the recording and investigation of medication errors.

Residents were now in receipt of their medication in a pre-dosed system from their local pharmacy. Due to this change in medication supply residents were now experiencing a more individualised pharmaceutical service.

**Judgment:**
Compliant

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### Outcome 13: Statement of Purpose

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The provider was required to submit a revised statement of purpose to reflect governance changes in the centre.

**Judgment:**
Substantially Compliant

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### 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*
责任和提供服务。

主题:
领导、治理和管理

先前检查中未完成要求:
无需采取任何行动。

发现:
检查员未在本次检查中对这一结果进行全面审查，因为它在上次检查中已被确认为符合要求。治理安排确保居民在新家有非常积极的体验，过渡到新中心管理得当。然而，还需要改进以确保持续改进。

改进包括任命一名全职负责人管理该中心以及中心特定的护理质量持续审计。

自上次检查以来，负责人职位已不再由该人担任。提供者已通知首席检查官该变更，作为临时安排已任命了一名符合第14条要求的合格且经验丰富的负责人来管理中心。

然而，此人也被任命为社区服务协调员，尽管他们符合该角色的要求，但他们没有全职任命，因此无法对两个角色分配的中心进行充分的监督。在检查期间，为填补这一职位正在开展全职负责人的面试。

尽管提供者为圣帕特里克中心发展了改进的审计系统，但在中心和员工层面，负责人的审计质量未得到充分重视。内审系统没有发现本次检查中发现的不合规。

判断:
基本符合

结果15: 负责人的缺位

首席检查官被通知负责人指定中心的拟缺位，以及在负责人缺位期间对指定中心的管理安排。

主题:
领导、治理和管理

结果15: 负责人的缺位

首席检查官须知会指定中心负责人拟缺位及其在负责人缺位期间对指定中心的管理安排。

主题:
领导、治理和管理

负责人的缺位

首席检查官需通知负责人的指定中心的拟缺位及其在负责人缺位期间对指定中心的管理安排。
**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The provider was aware of their responsibility to notify the Chief Inspector of the absence of the person in charge.

**Judgment:**
Compliant

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### 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

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

**Findings:**
The provider had adequately resourced the centre to meet the needs of residents. They had proposed to implement a responsive rostering for staff working in the centre. This had begun but not all staff were working off this rostering system at the time of inspection. However, this was a process the provider was engaging in with staff and did not appear to have a negative impact on the care and welfare of residents based on the inspection findings on this inspection.

**Judgment:**
Compliant

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### 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):
No actions were required from the previous inspection.

Findings:
This outcome was found to be in compliance on the previous inspection and therefore not all aspects of this outcome were reviewed on this inspection.

Now that staff were working and supporting residents in the centre, the inspector reviewed how staff were supervised and supported to do so.

While the person in charge had extensive experience in supervision, mentoring and management she had yet to establish a formalised supervision system with staff to date. This was mainly due to the responsibility remit she was managing at the time of inspection. This is referred to in outcome 14 of this inspection report.

At the time of inspection there were no documented supervision meetings available for review during the inspection.

Staff observed and spoken with told the inspector that they enjoyed working in the centre and the new model of service they were providing for residents was exciting and a positive challenge for them. The told the inspector that they had observed positive changes for residents and that the new home environment was meeting residents needs.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:
All schedule 5 policies required updating, review and revision to reflect the requirements of the regulations and guide staff in appropriate evidence based practices.
**Judgment:**
Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Saint Patricks Centre (Kilkenny)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005515</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>07 and 08 September 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>16 November 2017</td>
</tr>
</tbody>
</table>

**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:**

Improvement in gathering residents’ feedback and facilitation of choice was required. This was of particular importance in this centre given residents’ specific support needs with regards to communication.

1. **Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
and participates in the organisation of the designated centre.

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

- All Residents have individual communication passports and dictionary’s which assists communications.

- A Communication Champion will be assigned within the house. This person will focus on improving all aspects of communication for the residents.

- Residents meetings are now taking place weekly and facilitated by the Team Leader. The Team Leader attended a workshop focused on resident’s meetings organised by St. Patrick’s on 20/10/17.

- Residents will be supported to communicate by staff using their individual communication passports and dictionary’s during these meetings. Visual aids are used throughout the meeting to help with communication.

- Staff note any form of communication from the residents throughout the meeting and complete conditions for success form after the meeting which will capture feedback.

- The residents are offered choice for the food they eat. A food diary was kept for a month and from this a sample menu has been developed from resident’s likes and dislikes.

- Shopping lists are developed with residents using visual aids. Residents are supported to assist during grocery shopping using these visual aids and taking items off the shelves and placing them into the trolley.

- Residents have been sampling and will continue to sample new activities within their new community. Staff support residents to participate in these activities and use their knowledge of each resident’s way of communication to gauge how successful and meaningful the activity is. Conditions of success forms are used in planning and reviewing each activity to support this process.

**Proposed Timescale:** 06/11/2017

**Theme:** Individualised Supports and Care

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

Improvement was required in relation to the personal interests and hobbies options for residents while they were at home.

2. **Action Required:**

Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

**Please state the actions you have taken or are planning to take:**
• Sensory, art, play and beauty rooms have now been delegated to 4 members of staff.

• These staff have responsibility for sourcing equipment suitable and meaningful for the residents and requesting finance for same. Financial organisational resources to be secured for these programmes and their dedicated spaces.

• The OT and SALT had provided support regarding the sensory and play room equipment.

• OT and SALT facilitated 3 sensory MasterChef Sessions with residents and staff. A Powerlink buddy bottom has been purchased which enables residents to participate in food prep, personal grooming etc.

• OT and SALT facilitated a sensory stories with residents which was a great success therefore sensory stories are currently being developed and staff will support residents to participate in these stories.

**Proposed Timescale:** 31/12/2017

**Theme:** Individualised Supports and Care

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

The provider was required to facilitate residents in developing a meaningful connection with their independent advocate in light of their specific support needs.

3. **Action Required:**

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

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

• All residents will be facilitated to access the support of an independent advocate if and when required.
• The advocate will be invited to meet with the residents.
• Staff will support residents to participate and communicate in this meeting.
• Resident will be supported to access their advocate if they wish to make a complaint.
• All residents will be reviewed by the Human Rights Committee (Auditing Team) annually.

**Proposed Timescale:** 31/12/2017

**Theme:** Individualised Supports and Care

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

Improvement in the recording of complaints and the detailing the management of complaints was required to enable comprehensive auditing of complaints management.
4. **Action Required:**
Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

**Please state the actions you have taken or are planning to take:**
- New Complaints Policy was approved on 22/09/17 and a new complaints officer appointed. A request has been made to review this policy to ensure that the management of any complaints is robust and fit for purpose.
- Complaints policy will be read and discussed and reflected on at the next staff meeting.
- Staff to reflect on their role in terms of making complaints on behalf of residents.
- Easy read complaints policy is currently being updated and will reflect the current complaints procedure.

**Proposed Timescale:** 31/12/2017

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**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:
While residents had been issued a contract of care they had not been agreed with residents' and/or their representatives at the time of inspection.

5. **Action Required:**
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

**Please state the actions you have taken or are planning to take:**
- All Contracts of Care will be reviewed by the incoming Human Rights Committee. This committee has members who are not employed by the centre and have a legal background.

**Proposed Timescale:** 28/02/2018

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**Outcome 05: Social Care Needs**

**Theme:** Effective Services
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A more formalised approach to goal setting was required to ensure when a goal was identified an action plan was developed which set out the steps required to achieve the goal, evidenced inclusion of the resident in establishing those steps, who was responsible to complete each step and by what timeline.

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

Please state the actions you have taken or are planning to take:
• A new personal planning and recording tool is being circulated by the quality department having been reviewed by staff. This will be used going forward and integrated into the new Social Care Planning Pathway.

Proposed Timescale: 28/02/2018
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The personal planning system required improvement to ensure all assessed needs had plans in place to support residents.

7. Action Required:
Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

Please state the actions you have taken or are planning to take:
• The organisation has set up a Social Care Planning Working Group which has been tasked to identify a clearer Social Care Planning Pathway for residents.

• The team leader will discuss the importance of amending plans after any recommendations are made with all keyworkers and co-keyworker during individual supervision.

• The Team Leader will complete an audit on the resident’s files and develop an action plan.

• The actions will be delegated to the keyworker, co-keyworker and the staff nurse.

• A time frame will be placed on each action.

• The Team Leader will follow up each action during supervisions.
• The Team Leader Audits the resident’s files every quarter.

• The quality department carries out 6 monthly resident’s file audits, which is planned for the 4th week in February 2018.

**Proposed Timescale:** 28/02/2018

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### 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:

Vehicle maintenance records maintained did not evidence that the vehicle had received a service or check following the identification of an issue.

**8. Action Required:**

Under Regulation 26 (3) you are required to: Ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

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

• Vehicles checks are occurring weekly, and if any issues are identified they will be addressed immediately.

• Training to carry out vehicle checks is currently being organised by health and safety department for all staff.

• Transport is delegated to a staff member, which will be followed up during supervision.

• The health and safety department hold driving documentation for all staff that drives the work vehicle.

• All vehicles are to be fitted with a GPS tracking system that will inform us as to the mileage driven, driver behaviour (harsh braking, speeding etc), tyre condition, service due dates etc. This new system will ensure the centres meets its obligations under Regulation 26 (3).

**Proposed Timescale:** 28/02/2018

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### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Behaviour support planning for residents did not reflect the support requirements they needed for living in their new home.

**9. Action Required:**
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Please state the actions you have taken or are planning to take:**
- All Behaviour Support Plans will be reviewed by the Behaviour Support Specialist and updated to ensure they support the residents in the most positive and least restrictive manner.

**Proposed Timescale:** 30/01/2018

**Theme:** Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system for safeguarding residents from financial abuse required improvement.

**10. Action Required:**
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

**Please state the actions you have taken or are planning to take:**
- St. Patrick’s is currently developing a finance pathway which will include daily checks on resident’s personal funds, monthly checks by the Team Leader and a quarterly check by the community service manager. This will protect the resident’s finances from abuse and assign accountability.
- These checks will include a monitoring of the quality of spend in that period.

**Proposed Timescale:** 28/02/2018

**Outcome 10. General Welfare and Development**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessments of residents needs, had not included an assessment relating to residents' employment and education needs in line with their abilities and interests.

**11. Action Required:**
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to
access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
• Assessments relating to resident’s employment and education needs in line with their abilities and interests will be conducted using the Supports Intensity Scale tool.

Proposed Timescale: 30/03/2018

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 provider was required to submit a revised statement of purpose to reflect governance changes in the centre.

12. 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:
• A revised Statement of Purpose will be submitted to reflect governance changes in the centre.

Proposed Timescale: 30/11/2017

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 person in charge of the centre was not appointed in a full time capacity and could not provide adequate oversight of the centre given the two roles they were assigned to in the organisation.

13. 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:
• The paperwork to register the current Team Leader as PIC is being prepared for submission to the regulator.
• The Community Services Manager (CSM) as current PIC line manages and supervises the current Team Leader and holds monthly action planning meetings with the Team Leader to ensure adequate oversight.
• Both the CSM and the Team Leader attend fortnightly change management meetings with Senior Management which facilitate action planning, communication and accountability.
• CSM is line managed by the Director of Services who in turn is part of a senior management team and supervised by the director of operations and the board of directors of St Patricks Centre Kilkenny.

**Proposed Timescale:** 31/12/2017

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While the provider for St. Patrick's Centre had developed improved auditing systems throughout the service there was a lack of auditing of the quality of service and care provided to residents.

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

**Please state the actions you have taken or are planning to take:**
• The current annual schedule of audits for the centre is currently being reviewed and updated to ensure the focus for next year is on quality and not just compliance.

**Proposed Timescale:** 30/01/2018

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While a system was in place to ensure all staff received supervision meetings there were no documented supervision meetings available for review during the inspection.

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

**Please state the actions you have taken or are planning to take:**
• Community Service Manager is supervising Team Leader. Records of same are held in the CSM office in a secure press.
• Community Service Manager is supporting/mentoring Team Leader to supervise the staff team.

• Team Leader is carrying out supervisions with the staff team.

• Supervision schedule is in place and corresponds with the roster.

• Supervision may be requested by staff at any time.

• Supervision documentation is stored in the designated centre in a locked drawer.

• A key is now placed in a locked box to provide access to the regulator/senior management etc when the Team Leader is off duty.

**Proposed Timescale:** 06/11/2017

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**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

All schedule 5 policies required updating, review and revision to reflect the requirements of the regulations and guide staff in appropriate evidence based practices.

16. **Action Required:**

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

* The centre is currently reviewing and updating all schedule 5 policies to ensure they reflect current and agreed standards of practice.

**Proposed Timescale:** 30/03/2018