Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Whitmore Lodge
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	11 February 2019
Centre ID:	OSV-0005811
Fieldwork ID:	MON-0025425

About the designated centre

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

Whitmore Lodge is an eight bedroom unit situated on a campus based setting in Co. Louth. The centre was registered in October 2018 as a result of a larger unit on this campus closing. The centre can support eight male and female adults who have dementia. The centre is nurse led 24 hours a day. Healthcare assistants also play a significant role in supporting residents here. The person in charge is a qualified nurse and although they are responsible for two other centres, there is a clinic nurse manager in place to assist with the oversight arrangements in place. Residents are supported to access community facilities in line with their assessed needs. A bus is available to residents. Other activities are available in the centre which includes reflexology and music therapy. This centre has also been approved as a learning environment for student nurses.

The following information outlines some additional data on this centre.

Current registration end date:	25/10/2021
Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
11 February 2019	09:40hrs to 17:30hrs	Anna Doyle	Lead

Views of people who use the service

On arrival to the centre residents were being assisted by staff to have breakfast or some were getting up in their own time. The person in charge informed the inspector that the delivery of care was being planned around the residents' needs as opposed to the previous experiences for residents where institutional style practices were in place.

The residents met were unable to communicate their views to the inspector and in this instance the inspector observed some practices, reviewed documentation pertaining to residents' needs and their views; and spoke to staff in the centre. The details of this are contained further in this report.

The inspector observed that residents were relaxed in this centre which was peaceful and care was being delivered in a relaxed manner. Staff were observed sitting spending time with residents.

Capacity and capability

Overall the inspector found that governance and management systems in place were ensuring that a safe and effective service was being provided to residents, through ongoing auditing and monitoring practices. While improvements were required in some of the regulations inspected, the inspector found that for the most part these improvements had already been identified by the person in charge prior to this inspection.

There were clearly defined reporting structures in place. All staff reported to the person in charge and a clinic nurse manager. The clinic nurse manager and the person in charge met regularly to discuss the care and support needs of residents. The person in charge reported to the director of care and support, who attended the centre during the inspection.

Staff met were aware of these arrangements and said they felt supported in their role. Regular staff meetings were held. A sample of the minutes viewed found them to be comprehensive and that actions agreed by the team were being implemented. For example; at a recent meeting it had been agreed that residents should be supported by assigned staff each day to ensure that meaningful activities were completed. This was observed on the day of the inspection.

However, improvements were required to ensure that supervision was completed with all staff. This had already been identified by the person in charge who had

devised a schedule for the year to ensure that this was completed.

Training records for staff were reviewed. All staff had completed mandatory training and some outstanding training was scheduled to take place in the coming months. However, there was no plan in place for all staff to complete dementia training in this schedule.

At the time of the inspection there were adequate staffing levels in place to support residents. However, only six residents were residing in the centre. From a review of the staff rota, the inspector found that a number of staff who were on long term planned leave were not replaced. This required review so as to ensure that sufficient staffing resources and arrangements would be available when eight residents were residing in the centre. The person in charge had already highlighted this to the management team.

The person in charge demonstrated a commitment to continuous improvement measures in the centre. For example, they had requested an audit from the quality and safety team one month after the centre opened so as to assure that the services provided were meeting the needs of the residents. This was conducted on 27th November 2018 and evidence of some of the findings from this audit were observed. For example; it had been identified at this that improvements were required to ensure that residents were supported to maintain links with the wider community. Residents were observed being supported with this on the day of the inspection.

The person in charge had also registered this centre under a pilot quality improvement initiative which was being monitored by a registered nursing body.

Other audits completed, included a review of restrictive practices in the centre. This had been requested by the provider in all designated centres. The person in charge outlined some improvements that had been identified which were in the process of being addressed. For example; the policy on restrictive practices required some amendments in order to guide staff practice.

All recommendations from audits completed were recorded on a quality improvement plan for the centre. This document outlined the actions required and whether actions had been completed. The person in charge was knowledgeable about the actions outlined.

The Statement of Purpose was available in the centre. The inspector found that the type of care and supports being provided in the centre were not in line with those outlined in this document. For example, some residents were being admitted to the centre on short term basis and not for residential care. In addition; the staffing arrangements in the centre were not reflective of those outlined in the Statement of Purpose as discussed earlier in this report.

On review of the records maintained to monitor complaints the inspector found that they were addressed in a timely manner. Learning from complaints was also implemented. For example; the learning from one complaint had been discussed at

a team meeting to ensure that all staff were aware of this.

A copy of the incidents that had occurred in the centre since October 2018 were available in the centre. The inspector was satisfied that all incidents had been notified to HIQA in line with the regulations.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced. There were arrangements in place to ensure effective oversight of the centre given that the person in charge was responsible for three designated centres under this provider.

Judgment: Compliant

Regulation 15: Staffing

At the time of the inspection there were sufficient staff in place to meet the needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had completed training in dementia and there was no plan in place to address this.

Supervision had not been completed for all staff.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The type of care being provided in the centre and the staffing arrangements were

not in line with those outlined in the Statement of Purpose.

Judgment: Not compliant

Regulation 31: Notification of incidents

A copy of the incidents that had occurred in the centre since October 2018 were available in the centre. The inspector was satisfied that all incidents had been notified to HIQA in line with the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

All complaints were investigated promptly and learning from complaints was implemented in order to bring about positive outcomes for residents.

Judgment: Compliant

Regulation 23: Governance and management

The management structures in place were effective for the most part. Audits were conducted on the quality of care being provided in the centre. This was contributing to positive outcomes for residents. However, the management for the staffing arrangements and resources required review to ensure that sufficient staff were available when eight residents were residing in the centre.

Judgment: Substantially compliant

Quality and safety

Overall the inspector found that the quality of life for the residents had improved since transferring to this centre. Residents were observed being supported with their needs in a supportive and relaxed manner and all residents had their own bedrooms to facilitate this. Improvements were required in some of the regulations to ensure that equipment was appropriately maintained and to end of life plans in place for

some residents.

The premises were clean and decorated well. Some personal touches were still underway to residents' bedrooms and other areas of the centre at the time of the inspection. While some works remained outstanding both inside and outside of the property; the person in charge outlined the plans to address this.

Residents' bedrooms had been personalised with the help of staff and residents' representatives. Consideration had also been given to residents' particular interests in the centre. For example; one resident who loved the garden had double doors from their bedroom out to the garden area.

There was a large open plan dining room/sitting room which led into a conservatory. The kitchen was adequate and outside of this there was a small sitting area.

To the back of the unit there was a large decking area which residents could access. This overlooked a garden which is currently being landscaped to include a herb garden.

Bathrooms were of an adequate size and assistive aids were in place to support residents. Suitable arrangements were in place for the safe disposal of waste.

Arrangements were in place to ensure that some equipment in the centre was maintained. However, there were no records in the centre to demonstrate whether some clinical equipment was being serviced or maintained in line with the manufacturers' guidelines.

The inspector reviewed a sample of records pertaining to residents' personal plans. Each resident had an assessment of need completed and support plans were in place which detailed the support a resident required. The inspector viewed one end of life plan in place and found that it did not include or consider the will and preference of the resident and the document itself was not comprehensive.This was not respecting the residents' rights.

A sample of health care records viewed demonstrated that the needs of residents were responded to in a timely manner, with the support of allied health professional where necessary. Staff spoken to also demonstrated a very good knowledge of the residents' needs in the centre. A personal plan tracking sheet was also in place to ensure that residents' plans were updated regularly.

The inspector viewed one end of life plan in place. While relevant allied health professionals and the resident's representative had been involved in devising this plan, the will and preference of the resident had not been considered or included in the plan. This was not respecting the rights of the resident.

Resident's food was prepared in a kitchen outside of the centre. However, residents were able to choose their meal preferences through weekly meetings.

Residents who required support around food and nutrition had this highlighted in their personal plan. From a sample viewed, allied health professionals had been

involved in the residents care. The plans were also reviewed when there was a change observed in residents' needs. Staff were very aware of the needs of the residents in this regard and arrangements in personal plans were observed being implemented into practice.

Residents' were supported to access meaningful activities in line with their assessed needs. On the day of the inspection a number of residents went out on community activities and others availed of activities in the centre.

Activity schedules were planned at weekly residents meetings. At these meetings residents were also informed about aspects of service delivery. For example; an update was provided to two residents who were awaiting the arrival and installation of a new bath.

Maintaining links with family members was also observed to be supported for the residents. For example, the inspector was informed of a Christmas party held to celebrate the opening of the centre. Family members had attended this.

There were arrangements in place for containing and responding to fire. For example; fire doors, emergency lighting, a fire alarm and fire fighting equipment had been installed. Each resident had a personal emergency evacuation plan in place and a fire drill had been completed in the centre to demonstrate a safe evacuation of the centre.

A staff member was assigned each day to oversee an evacuation of the centre if required. Another staff member was responsible for completing daily fire checks. All staff had completed fire safety training which included on site fire safety evacuation.

There was an established risk management framework in the centre. This included a review of all incidents in the centre to identify trends and inform learning. Residents had individual risk management plans in place and from a sample viewed they contained control measures to mitigate risks to residents. A risk register was also maintained by the person in charge.

All staff had completed training in safeguarding vulnerable adults. Staff were aware of what constituted abuse and the reporting procedures in place in such an event.

There were arrangements in place to support residents with their finances and personal belongings. For example; a record of residents personal belongings was maintained. A sample of residents' financial records viewed found that there were some mechanisms in place to safeguard residents' finances. For example; two staff checked and signed that residents' records and finances were accurate.

The provider also intended to implement an audit of residents' financial records periodically during the year. However, there were no checks completed by managers or the person in charge to ensure that all financial transactions were accurate.

Regulation 11: Visits

Residents were supported to receive visitors in the centre.

Judgment: Compliant

Regulation 12: Personal possessions

There were no checks completed by managers or the person in charge to ensure that all financial transactions were accurate.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents' were supported to access meaningful activities in line with their assessed needs.

Judgment: Compliant

Regulation 17: Premises

There were no records in the centre to demonstrate whether some clinical equipment was being serviced or maintained in line with the manufacturers' guidelines.

The inspector was satisfied that the premises were appropriate in meeting the assessed needs of the residents.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents who required support around food and nutrition had this highlighted in their personal plan. Plans were reviewed when there was a change observed in

residents' needs.Allied health professionals had been involved in the residents care.

Judgment: Compliant

Regulation 26: Risk management procedures

There was an established risk management framework in the centre which included a review of all incidents, individual risk assessments for residents and an up to date risk register.

Judgment: Compliant

Regulation 28: Fire precautions

There were adequate fire precautions systems in place in the centre to include a fire alarm and a range of fire fighting equipment such as fire extinguishers, fire blankets and emergency lighting. Each resident had a personal emergency evacuation plan in place and a fire drill had been completed in the centre to demonstrate a safe evacuation of the centre.

All staff had completed training in fire safety which included on site fire evacuation training.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need completed and support plans were in place which detailed the support a resident required.

Judgment: Compliant

Regulation 8: Protection

All staff had completed training in safeguarding vulnerable adults. Staff were aware

of what constituted abuse and the reporting procedures in place in such an event.
Judgment: Compliant
Regulation 6: Health care
An end of life plan in place did not include details of the will and preference of the resident.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 6: Health care	Not compliant

Compliance Plan for Whitmore Lodge OSV-0005811

Inspection ID: MON-0025425

Date of inspection: 11/02/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 15 of the 25 core staffing team have completed dementia training, 5 will complete by May 2019 and the final 5 by 20th May 2019. Staff attendance is monitored by the house manager and person in charge against the training schedule. A schedule is in place to complete staff supervision.	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The statement of Purpose has been updated on the 13/02/2019 post inspection. The criteria for admission to the designated centre has been updated to specifically include emergency and short term admissions from across the SJOG Service.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The staffing complement for full occupancy of the Centre is 17.23 full time equivalents.

Staffing levels were determined and agreed with senior management and the local Transforming Lives Team as part of the transition to the designate centre, based on the needs of the transitioning residents.

Rosters are developed around residents needs and are flexible enough to facilitate additional support for individual residents as may be required from time to time.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The Provider has reviewed and updated their policy on resident's personal finances, consistent with the HSE's guidance.

In line with this policy, the house manager has commenced monthly financial checks of each resident's financial ledger. This is recorded in each ledger.

The person in charge will conduct (and record) quarterly financial checks of each resident's financial ledgers and bank statements.

The person in charge has also completed an annual expenditure review to ensure each resident's finances are being utilised appropriately, consistent with their expenditure commitments, preferences and available funds.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The person in charge has reviewed all the clinical equipment within the designated centre and identified specific items of equipment that require scheduled servicing.
A maintenance schedule/record has been developed with the maintenance supervisor to coordinate the monitoring and recording of equipment servicing.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The guidelines for the end of life plan have been reviewed and updated to specify emotional and spiritual supports, the decision making process regarding the use of medical directives, active treatment, physical environmental needs, dignity and respect at end of life and comfort supports.

The amended 'plan' will be introduced to residents and their key workers in May 2019.

Each resident will be supported to have an end of life care plan developed that respects their end of life wishes

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	30/05/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	20/05/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately	Substantially Compliant	Yellow	30/05/2019

	supervised.			
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	30/06/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/06/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	13/02/2019
Regulation 06(3)	The person in charge shall ensure that residents receive support at times of illness and at the	Not Compliant	Orange	10/06/2019

	end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.			