Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Leaby Lodge
Name of provider:	MMC Children's Services Limited
Address of centre:	Louth
Type of inspection:	Short Notice Announced
Date of inspection:	15 June 2021
Centre ID:	OSV-0005366
Fieldwork ID:	MON-0032911

About the designated centre

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

The centre consists of a two-story dormer-style house located in a rural setting but within a relatively short driving distance of a small town. The upper floor of the house consisted of three bedrooms, one of which was en suite. There were two further bedrooms on the ground floor and bathroom facilities on both floors. There was adequate communal accommodation in place, with a large kitchen come dining area and a sunroom. The ground floor of the centre was wheelchair accessible throughout and observed to be suitably decorated with adequate furnishings, fixtures, and fittings. There was a good-sized garden surrounding the property suitable for children to play in, and there were various items of accessible play equipment. There was transport available to residents in order to ensure that they could access nearby towns and engage in their preferred activities. The residents received twenty-four-hour care from a staff team that consisting of a Clinical nurse manager, care staff, and social care support staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Tuesday 15 June 2021	10:00hrs to 16:30hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

The inspection was undertaken in a manner so as to comply with public health guidelines and reduce the risk of infection to the residents and staff in the centre.

Through observations and review of residents' information, the inspector found that residents received appropriate care and support. Where possible, residents were supported to engage in activities of their choosing, and the centre's staff team supported residents in a way that promoted their views and rights. The inspector observed warm and friendly interactions between residents and the staff team supporting them throughout the inspection.

On arrival to the centre, the inspector observed one of the residents engaging in activities with a staff member in the garden. The provider had developed a sensory garden for residents to use, and this had been laid out to meet the needs and preferences of the residents. The inspector was supported to interact with the resident for a period. The resident and the inspector played catch as the person in charge supported the interaction. The resident appeared happy in their environment and the staff members supporting them were aware of the resident's communication needs and preferences.

The inspector met with the second resident towards the end of the inspection. The resident had been attending school and was being supported to engage in stretching time on their return. The resident again appeared comfortable in their environment. The resident was relaxing in their room which was decorated to their preferred taste with posters of their favorite tv show and other personal items displayed throughout. The person in charge and a staff member supported a conversation between the resident and the inspector. The staff members were again aware of the resident's communication needs.

A review of residents' information demonstrated that they were receiving person-centered care that was developed in line with their needs. Weekly resident meetings were held that gave residents an opportunity to choose meals and activities they wished to engage in. There were also regular individual work sessions being carried out between residents and staff members. These sessions were linked to goals that had been identified for residents during the development of their placement plans. Residents were being supported to attend their educational placements. They were also supported to maintain their education programmes when unable to attend school due to medical treatments or school closures due to the COVID-19 pandemic.

There was evidence that residents were beginning to re-engage in community activities following the lifting of restrictions. One of the residents had recently celebrated a birthday and was supported to visit Tayto Park along with their peer. Overall there were strong auditing practices regarding residents' information that ensured that the changing needs of residents were being monitored and responded to. The inspection did, however, find that there were improvements required

regarding other monitoring practices. The impact of this will be discussed in more detail in the following Capacity and Capability and Quality and Safety sections of the report.

The inspector had the opportunity to speak with two residents' family members; both spoke positively of the service being provided to their loved ones. They expressed that they were kept informed regarding the care being provided to their family members and that they could, before COVID-19, visit the service whenever it suited.The family members that spoke with the inspector were overall happy with the service being provided to their loved ones.

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

Capacity and capability

As stated in the first part of the report, residents' information was under regular review and was effectively monitored. The inspection, however, found that there were improvements required regarding the monitoring of training and staff development records, medication management practices, and ensuring that notifications were submitted within the appropriate time as per the regulations. There were also concerns identified in regard to ensuring that there were sufficient staffing numbers present each day to meet the complex needs of the two residents.

The provider had ensured that there was a management structure in place that was led by a person in charge, and a deputy person in charge. There was a strong management presence, and in general, this led to the effective delivery of care. The provider had completed the required reviews and reports focusing on the quality and safety of care provided in the centre as per the regulations. Actions had been identified following these, and there were appropriate systems in place that ensured that identified actions were being addressed. The most recent audit had been completed in May, and there was evidence of identified actions being addressed promptly.

A review of the staff team's training needs analysis record identified a number of gaps in staff members' required training. These included basic life support, fire safety training, and therapeutic crisis intervention training. While the provider had been seeking to arrange training, there were significant delays in the sourcing of some training in particular, basic life support training for four staff members. This was despite the two residents living in the centre presenting with high support needs regarding their health. The inspector notes that during the course of the inspection that basic life support training was sourced; however, there were significant delays in this being achieved. The inspector was also assured that the other outstanding training was due to be completed in the coming weeks.

The staff team supporting residents was made up of a Clinical nurse manager, care staff, and social care support staff. A review of planned and actual rotas displayed that, in general, three staff members were assigned to support residents during each day. There were, however, occasions where only two members were rostered. Both residents require two to one staffing support with personal care and transfers. The centre's person in charge and deputy person in charge supported the staff team if only two members were on shift. This was, however, not always possible as there were occasions where only two staff members were rostered at weekends when the management team were not present in the centre. There was, therefore the potential for the staff members being unable to meet the needs of both residents for periods when only two staff members were rostered.

The provider, in their most recent audit, had identified that there was a need to ensure that there were appropriate staffing numbers each day. There had been two recent resignations amongst the staff team, and this was impacting upon this. The provider had sourced one-night duty staff, but there was still a requirement to source an additional staff member.

For the most part, the person in charge was submitting the necessary notifications for review by the Chief Inspector as per the regulations. There were, however, improvements required to ensure that all adverse incidents as listed in the regulations that occurred in the centre were reported within the prescribed period.

There was an effective complaints procedure that was accessible to residents. The inspector observed that the complaints procedure had recently been addressed during resident individual work sessions. A review of the centre's complaints log showed that there had been a complaint raised by a family member. This was addressed by the centre's person in charge promptly, and the family member expressed that they were happy with the outcome.There was some attention required to ensure that the complaints log was appropriately updated following submission of a complaint. The inspector was, however, assured that a recent complaint was being addressed by the provider and the person in charge.

Overall, there were improvements required to the monitoring practices in a number of areas. The service being provided to residents was, for the most part, effectively monitored and was leading to positive outcomes for residents.

Regulation 15: Staffing

There were improvements required to ensure that the number of staff on shift each day was sufficient to meet the needs of both residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider and person in charge had not ensured that all members of the staff team had access to appropriate training, including refresher training as part of a continuous professional development programme.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector was not assured that the existing management structures and monitoring practices were appropriate. There were improvements required to ensure that all aspects of the service were effectively monitored.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

There were improvements required to ensure that all adverse incidents as listed in the regulations that occurred in the centre were reported within the prescribed period.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure that was accessible to residents.

Judgment: Compliant

Quality and safety

As discussed in the earlier sections, there were required improvements to medication management practices. The inspector found that there were not appropriate or suitable practices relating to the prescribing and storing of

medication.

A review of the residents' medication records demonstrated that a medication had been prescribed by a residents pediatrician, with a plan put in place to increase the medication over six days. The provider sought the resident's General Practitioner (GP) to update the medication Kardex (record) to capture the changes. This, however, had not been completed in full; the inspector found that, as a result, the staff team were administering a medication that was not listed as per the medication record and, as a result, were not following their own policies and procedures.

There had also been occasions where the provider's safety control measures put in place to ensure the safe storage of medication were not followed by all staff members. The inspector notes that improvements and more stringent systems had been implemented in recent weeks. These were, however, implemented retrospectively, and there was a requirement for improved monitoring concerning medication management practices.

The provider had ensured that assessments of residents' health and social care needs had been carried out. Placement plans had been developed for both residents, and there was evidence to demonstrate that the needs of the residents were being met by the team supporting them. These plans shaped the service being provided to the residents and were treated as live documents. Both residents' placement plans were also due for review and update in the days following the inspection.

Residents were engaged in weekly meetings. The person in charge had developed a schedule of topics to be reviewed during meetings; the meetings aimed to promote information sharing and learning for the residents. Where possible residents were encouraged to choose activities of their choosing. There were also a number of goals developed for the residents that were focused on community and social inclusion along with engaging the residents in their preferred activities.

There were arrangements that assured that each resident was receiving or had access to appropriate health care. Both residents presented with complex health needs, and there was evidence of input being provided by a range of allied healthcare professionals and therapeutic services. Residents were facilitated to attend a range of medical appointments. There was evidence of the staff team acting as advocates at times regarding the treatment plans and following up with prescribers to ensure that the plans were the most appropriate options.

There were systems in place to manage and mitigate risks and keep residents and staff members safe. The provider had arrangements in place to identify, record, investigate, and learn from adverse incidents. Adverse incidents were discussed as part of team meetings, and learning from incidents was promoted.

Infection control arrangements at the centre were robust and reflected current public health guidance associated with managing a possible outbreak of COVID-19. The person in charge had developed a COVID-19 response plan for the centre, which informed staff of actions to be taken in all eventualities, including an outbreak amongst residents, staff members, or staff shortages. The COVID-19 risk

assessments developed for residents, the staff team, and visitors were detailed and developed according to the Health Protection Surveillance Centre (HPSC) guidelines.

Overall, the provider and person in charge had ensured that there were systems in place to provide good quality service to residents.

Regulation 13: General welfare and development

The person in charge and the staff team were promoting residents' general welfare and development.

Judgment: Compliant

Regulation 26: Risk management procedures

The centre had appropriate risk management procedures in place. There were also policies and procedures for the management, review and evaluation of adverse events and incidents.

Judgment: Compliant

Regulation 27: Protection against infection

The provider and the person in charge had adopted procedures consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that there were not appropriate or suitable practices relating to the prescribing and storing of medication.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider's multidisciplinary team and person in charge had developed individualised supports for residents and these were promoting positive outcomes for residents.

Judgment: Compliant

Regulation 6: Health care

The health needs of residents were under review. They had access to appropriate healthcare services on the same basis as others in order to maintain and improve their health status.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were facilitated and empowered to exercise choice and control across a range of daily activities and had their choices and decisions respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Leaby Lodge OSV-0005366

Inspection ID: MON-0032911

Date of inspection: 15/06/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A recruitment drive is in place to source additional core staff to supplement the team to ensure that 3 staff are on duty to better meet the needs of the residents. The provider has requested in writing additional funding from HSE to finance additional staffing costs. The roster has been updated to ensure 3 daily staff are on shift and agency staff are in use where required. All staff in use will be compliant with Regulations Schedule 2 in respect of required documentation.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The training schedule is in place with identified training dates to include refresher training where applicable. This training is already in completion. Training will be monitored more closely moving forward within monthly supervision of staff with enhanced oversight of training requirements in line with Regulation 16.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Management will enhance monitoring of all systems in the centre to ensure that a safe, quality service is provided consistently in line with all Regulations. A particular emphasis will be placed on identified areas within this report that highlighted that full compliance has not been achieved with some Regulations.

Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: HIQA portal users (Person In Charge and Deputy Manager) will undertake refresher study of Regulation 31 and the HIQA guidance documentation regarding same to ensure that all notifications are submitted within the correct reporting time frame.	

Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The person in charge will ensure closer monitoring/ auditing of medication management. The Medication management systems were reviewed and updated to promote safer medication management practices to include safe storage of medication. The Medication management policy has been updated. Staff have attended refresher training in the Safe Administration of Medication. Medical protocols will be completed or signed off by the prescriber. All residents Kardex's will be completed by the prescriber and will only be accepted for use once management are satisfied that these documents ensure safe medication administration practice to guide staff.	

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/07/2021
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.	Not Compliant	Orange	31/07/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/07/2021

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	31/07/2021
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.	Substantially Compliant	Yellow	16/07/2021