Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Whitmore Lodge
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Short Notice Announced
Date of inspection:	19 October 2020
Centre ID:	OSV-0005811
Fieldwork ID:	MON-0030663

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 can support eight male and female adults who require nursing support due to changing medical needs. The centre is nurse led 24 hours a day. Health care assistants also play a significant role in supporting residents here. There are six staff allocated to work during the day with residents and three staff at night time. Household staff also work during the day. The person in charge is a qualified nurse and although they are responsible for one other centre, 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.

Number of residents on the date of inspection:	7

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
Monday 19 October 2020	10:40hrs to 16:45hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

Due to the current COVID-19 restrictions and public health advice, the inspector only visited the centre for a short time to meet the residents and staff. The rest of the inspection was conducted in a building close to the centre.

As some of the residents were still in bed, the inspector met three of the residents. One resident showed the inspector their room. This was an area that the resident liked to spend a lot of time in, and it had been personalised to their taste. The resident had chosen their own paint colour for their room and had helped to paint it. It included items that were important to them and pictures of their family members and places they had visited in the past.

One resident said that they liked living there and liked the staff. The residents looked well cared for and appeared to have good relationships formed with the staff. Staff were observed to understand and respect the communication style and preference of each resident and supported them to make their own choices. For example; two residents were observed voicing their choices and staff facilitated these.

The staff and speech and language therapist were also conducting communication assessments with each resident to develop individualised communication supports for them. This assessment aimed to further enhance the supports provided for residents.

Residents were able to get drinks and snacks when they chose to. There was a small coffee dock beside the kitchen where residents could enjoy a coffee.

As a result of the public health restrictions due to COVID-19, residents activities had been limited outside of the centre. However, staff and residents had taken on a project to do up the garden area during this time, which was now full of colourful plants and had seating areas where residents could sit and enjoy.

The staff had also put together a reflective journal, showing how the lives of residents had changed during COVID-19. This depicted the struggles residents and staff had dealt with during the initial lock down and how throughout this very difficult time that they managed to support the residents to have some meaningful activities.

For example; the inspector saw from this that residents were supported to enjoy some activities such as gardening, painting their room or simply enjoying the weather in their back garden.

Residents' meetings were held weekly. A sample of minutes viewed found that residents were consulted on menus/ activities and were also being informed of

issues pertaining to the centre.

The centre was homely, personalised and very clean on the day of the inspection and assistive aids were in place to support residents.

Capacity and capability

Overall the inspector found that the staff and management team were providing a safe quality service to the residents. However, the provider had failed to appropriately respond to a complaint raised on behalf of residents which was impacting on their rights. The guidelines and practices in relation to end of life planning did also not include how residents are included in these decisions. Some improvements were also required to the records stored in residents' personal plans.

The person in charge was a qualified nurse, with considerable years of managerial experience working in the disability sector. They were supported in their role by a clinic nurse manager to ensure effective oversight of the centre.

There were clearly defined reporting structures in place. All staff reported to the person in charge and the clinic nurse manager. The person in charge reported to a director of care and support.

There were governance and management arrangements in place to ensure that services were reviewed and monitored. An annual review had been completed along with six monthly quality and safety reviews. The last one completed in June 2020, demonstrated that the person in charge was implementing the findings from this in order to improve services. For example, there were now records available to show that all medical equipment had been serviced. Technology was also now in place so as residents could maintain contact with family members.

A number of audits had been completed in the centre which included, infection control procedures and residents' personal plans. The inspector found in general, that the reports generated from these audits found good practices were maintained in the centre and actions developed on how practices could be improved had also been implemented. For example; a recommendation from an infection control audit to ensure that cleaning schedules were wall mounted had been completed.

However, the provider had not responded to a complaint raised on behalf of residents, which had also been raised in the annual review 2019 for the centre which related to the pathways outside the centre which were damaged. This is discussed under regulation 9 residents' rights.

There were sufficient staffing levels in the centre which included contingencies to cover staff leave. The skill mix included nurses and healthcare assistants. Staff said

that they felt supported by the person in charge, the clinic nurse manager and the wider management team. In particular the staff were very complimentary of the support received from the senior management team throughout the COVID-19 pandemic.

Staff meetings were held regularly and issues pertaining to the centre were discussed. Staff felt that they could raise a concern to any of the management team.

Two personnel files reviewed were found to contain the requirements set out in the regulations. This included up to date Garda vetting records.

Staff had also been provided with training in order to support the residents. The records showed that staff had undertaken training in safeguarding of vulnerable adults, positive behavioural support, manual handling and fire safety. Other training made available to staff included, food hygiene, infection control and dementia training.

Some refresher training and training had been postponed due to the current COVID-19 restrictions. However, the provider was now in the process of starting some refresher training programmes (pending public health advice). One staff member was due refresher training in infection control, and the person in charge had a plan to address this in the coming days using online sources.

The inspector found that for the most part the records stored in residents' personal plans were comprehensive and up to date. However, some records had not been updated to include the most relevant information. For example; a record where a residents' representative had been included in the decision for an end of life plan had not been signed by the representative. And one residents plan had not been updated to include a the full review conducted by an allied health professional (however, this had been addressed prior to the end of the inspection).

Regulation 14: Persons in charge

The person in charge is a qualified nurse, with considerable years of managerial experience working in the disability sector. They were supported in their role by a

clinic nurse manager to ensure effective oversight of the centre.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staffing levels in the centre which included contingencies to cover staff leave. The skill mix included nurses and health care assistants. Staff said that they felt supported by the person in charge, the clinic nurse manager and the wider management team. In particular the staff were very complimentary of the support received from the senior management team throughout the COVID-19 pandemic.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had also been provided with training in order to support the residents. The records showed that staff had undertaken training in safeguarding of vulnerable adults, positive behavioural support, manual handling and fire safety. Other training made available to staff included, food hygiene, infection control and dementia training.

Some refresher training and training had been postponed due to the current COVID-19 restrictions. However, the provider was now in the process of starting some refresher training programmes (pending public health advice). One staff member was due refresher training in infection control, and the person in charge had a plan to address this in the coming days using online sources

Judgment: Compliant

Regulation 21: Records

Some records had not been updated to include the most relevant information. For example; a record where a residents' representative had been included in the decision for an end of life plan had not been signed by the representative. And one residents plan had not been updated to include a the full review conducted by an allied health professional (however, this had been addressed prior to the end of the inspection).

Judgment: Substantially compliant

Regulation 23: Governance and management

There were governance and management arrangements in place to ensure that services were reviewed and monitored.

The provider had arrangements in place to carry six monthly quality and safety reviews and an annual review as required under the regulations.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose containing the information set out in Schedule 1 of the regulations. This had also been reviewed as required.

Judgment: Compliant

Quality and safety

Overall the inspector found that the quality of care being provided in the centre was to a very good standard and that residents appeared happy there. Notwithstanding; improvements were required to ensure that the provider was taking appropriate actions to ensure that residents' rights in the centre were upheld.

The inspector found some examples of where residents were supported to exercise their rights in the centre through a number of ways. For example: residents meetings were held weekly to discuss issues that were happening in the centre. Key working meetings were also held to discuss more specific areas concerning the residents care and support.

Staff also advocated on behalf of residents to raise complaints. However, as mentioned earlier in the report, the provider had failed to address a concern raised on behalf of residents regarding the pathways outside the centre. This was impacting on the rights of the residents to enjoy accessing some of the outside areas due to the state of the pathways. This was also causing residents wheelchairs

to be damaged. This needed to be addressed.

It was also not clear how residents had been included in their end of life care. There was a guide in place to support the implementation of these plans; however, this guide did not reflect current best practice guidelines in relation to how residents should be supported with and included in these decisions.

The inspector was informed that the provider had recently developed a new procedure in relation to consent to guide improvements in this area. The person in charge was aware that this new procedure would support improvements in this process in the centre going forward.

A sample of records pertaining to residents' personal plans was reviewed. Each resident had an assessment of need completed and support plans were in place which detailed the support a resident required. These plans were reviewed to assess the effectiveness of the supports and care being provided.

An annual review had been conducted which included the resident or their representative where appropriate. Some goals had been developed, however many were postponed due to public health guidelines in place.

Residents had access to numerous allied health professionals to support them. Some of which included an occupational therapist, physiotherapist, clinic nurse specialists and a speech and language therapist. Recommendations from these professionals were being implemented. For example; if a resident required their fluid intake to be monitored then this was completed daily.

Residents had been supported to access national health screening initiatives where advised.

The inspector viewed one end of life plan in place and found that it outlined the care and support to be provided and included consultation with the residents' representative. The resident had also attended some of the meetings. However, as discussed under regulation 9, the residents' views had not been documented.

Risk management systems included a risk register and a site specific safety statement which highlighted the main risks in the centre. Incidents were reviewed to identify trends and inform learning. Where trends had been identified measures had been taken to mitigate risks. For example; a hand rail had been put in place for a resident who was at risk of falls. Residents had individual risk management plans in place and from a sample viewed they contained the control measures to mitigate risks.

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.

The provider had infection control measures in place to prevent/manage and outbreak of COVID-19. This included standard operating procedures specifically relating to the management of COVID-19 in order to guide staff practice. A COVID-19 response plan was also available to guide staff on what to do if a resident

needed to self isolate.

A number of staff had been trained to swab residents if required. This was put in place to allay any potential fears for residents, as someone they knew and who knew them well could support them with this procedure.

Staff had been provided with training in infection control, hand hygiene and personal protective equipment. Staff were knowledgeable about the procedures in place and were observed wearing face masks as required. Hand sanitising units were in place in the centre. Both staff and residents were checked for symptoms of COVID-19 twice a day. Procedures were also in place when residents were discharged from hospital.

There were contingencies in place to manage a shortfall of staff and staff did not move to other centres on the campus to minimise the risk of infection.

Increased cleaning practices were in place and it was evident that these were being implemented as the home was very clean and well maintained.

Regulation 26: Risk management procedures

Risk management systems included a risk register and a site specific safety statement which highlighted the main risks in the centre. Incidents were reviewed to identify trends and inform learning. Where trends had been identified measures had been taken to mitigate risks. For example; a hand rail had been put in place for a resident who was at risk of falls.

Residents had individual risk management plans in place and from a sample viewed they contained the control measures to mitigate risks.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had infection control measures in place to prevent/manage and outbreak of COVID-19. This included standard operating procedures specifically relating to the management of COVID-19 in order to guide staff practice. A COVID-19 response plan was also available to guide staff on what to do if a resident

needed to self isolate.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A sample of records pertaining to residents' personal plans was reviewed. Each resident had an assessment of need completed and support plans were in place which detailed the support a resident required. These plans were reviewed to assess the effectiveness of the supports and care being provided.

An annual review had been conducted which included the resident or their representative where appropriate. Some goals had been developed, however many were postponed due to public health guidelines in place

Judgment: Compliant

Regulation 6: Health care

Residents had access to numerous allied health professionals to support them. Some of which included an occupational therapist, physiotherapist, clinic nurse specialists and a speech and language therapist. Recommendations from these professionals were being implemented. For example; if a resident required their fluid intake to be monitored then this was completed daily.

Residents had been supported to access national health screening initiatives where advised.

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 9: Residents' rights

Some examples of where residents were supported to exercise their rights in the centre were observed. However, the provider had failed to address a concern raised on behalf of residents regarding the pathways outside the centre. This was impacting on the rights of the residents to enjoy accessing some of the outside areas due to the state of the pathways. This was also causing residents wheelchairs to be damaged.

It was also not clear how residents had been included in their end of life care. There was a guide in place to support the implementation of these plans; however, this guide did not show how residents should be supported in their end of life care.

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
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Whitmore Lodge OSV-0005811

Inspection ID: MON-0030663

Date of inspection: 19/10/2020

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The resident's family representatives have signed the record in relation to the decision in the end of life plan. The Person in Charge and the House manager continue to audit the Individual personal plans and documentation to ensure they are completed accurately.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: All documentation in relation to the advanced medical directive as part of the end of life decision will remain in the resident's active individual personal plan. This is to ensure there is an accurate account of all decisions made in relation to end of life care. The Person in Charge will review the advanced medical directives as part of the end of life documentation to ensure it reflects how the resident has being involved & how their natural advocates support them in this decision making process. The Person in Charge will liaise with the local Human Rights committee in relation to consent. The Register Provider will review the pathways outside the Designated centre with review to repairing them to support residents to access some of the outside areas.	

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 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/10/2020
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	10/12/2020
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with	Not Compliant	Orange	30/05/2021

	his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.			