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 (Children)

Name of designated centre:	Leaby Lodge
Name of provider:	MMC Children's Services Limited
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	08 August 2019
Centre ID:	OSV-0005366
Fieldwork ID:	MON-0027528

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 storey 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 sun room. 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 are currently two children with disabilities resident in the centre, and this inspection was conducted following the providers application to increase the number to three. There were three staff on duty at all times, which included twelve hours per day nursing cover. The provider had undertaken to increase the staffing numbers to meet the needs of any new admission.

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
08 August 2019	09:30hrs to 16:30hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

There were two children resident on the day of the inspection, and both responded to the inspector in their individual ways. It was not possible to verbally communicate with the children, but it was clear that the staff and person in charge had devised various strategies of offering choice and eliciting opinions. The inspector observed the children to be enjoying different aspects of their day, and to be comfortable in their home. The children interacted with staff in a positive way, and had their choices respected throughout the day.

A detailed daily record was maintained for each child, and the response of children to daily choices was documented so that it was clear that their voices were heard. The relatives of children were involved in decisions made in the centre, and in particular in the decision to offer a third child a placement, and relatives all supported this.

Capacity and capability

There were management and governance processes in place, including a clearly defined management structure, and monitoring processes which were effective in ensuring robust oversight of the centre. However the provider had not prepared an annual review of the quality and safety of care and support in the designated centre as required by the regulations.

Governance systems included a system of audits and effective communication throughout the staff team. There were detailed audits of various aspects of support including medication management, nutrition and documentation. Six monthly unannounced visits on behalf of the provider had been undertaken. These processes resulted in action plans where required, and the implementation of these actions were monitored until complete, thus ensuring continuous quality improvement.

Regular team meetings were held in the designated centre, and all aspects of care delivery and operation of the centre were discussed at these meetings. Each meeting began with a review of the required actions from the previous meeting, and outcomes were recorded. The organisation had a staff newsletter so that information was effectively shared throughout.

The provider had ensured that key roles within the centre were appropriately filled. The person in charge was appropriately experienced and qualified, and showed evidence of effective practice development, including in the improvement of communication strategies for residents.

There was a detailed Statement of Purpose in place, which accurately described the service offered to residents.

The provider had arrangements in place to ensure a consistent staff team was in place. The number and skills mix of staff was appropriate to meet the needs of residents. There was a core team of staff, and where the infrequent use of agency staff was required, the agency staff member would always be on duty with other staff who were familiar with the centre and the residents. Staff were in receipt of regular training, both mandatory training and training in aspects of care specific to individual residents. Provision was already underway to ensure staff were in receipt of training pertinent to the potential new resident.

Staff engaged by the inspector were knowledgeable about the support needs of residents, and about any interventions required for residents. A sample of staff files reviewed by the inspector included all the information required by the regulations. Staff supervision took place regularly and it was apparent that staff were supported to provide safe and quality care to residents in accordance with their needs and preferences.

There was a clear complaints procedure in place which was readily available, and a log was maintained which included a record of both complaints and compliments received. The person in charge utilised various communication strategies to ensure that residents had information about making a complaint.

Overall the inspector found that there were robust systems of oversight of the centre, that issues were addressed in a timely manner, and that residents were supported to enjoy a good quality of life.

Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, had a detailed knowledge of the support needs of residents and was involved in oversight of the care and support in the centre.

Judgment: Compliant

Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training and additional training specific to the needs of residents, and were appropriately supervised.

Judgment: Compliant

Regulation 31: Notification of incidents

All the necessary notifications had been made to HIQA within the required time frames.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider was aware of the requirement to notify HIQA of periods of absence of the person in charge. No absences were anticipated.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

Appropriate arrangements were available in the event of an absence of the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. Relatives were aware of how to make a complaint and the process was discussed with residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place which identified the lines of accountability and authority. There were effective monitoring systems in place. However the provider had not prepared an annual review of the quality and safety of care and support.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose included all the required information and adequately described the service.

Judgment: Compliant

Quality and safety

The provider had put arrangements in place to ensure that residents had support in having a good quality of life, in learning and development and in having access to healthcare.

The premises were suitable to meet the needs of residents. Each resident had their own room, which was furnished and decorated in accordance with their preferences, and located in an area of the house which supported their mobility needs. There were various private and communal living areas both inside and outside the premises, including a spacious play area designed specifically to meet the needs of the individual residents.

Each resident had a personal plan in place based on an assessment of needs. These plans were detailed and person centred, and had been regularly reviewed. Both social and healthcare needs were included in the personal plans, and goals had been set with each resident to support them to maximise their potential. A detailed record was maintained throughout the day of the activities and progress of each resident.

Personal plans also included detail in relation to communication with residents, and various strategies were outlined to meet the individual needs of residents, including the introduction of new approaches. Where resident required positive behaviour

support this was provided by the multi-disciplinary team, and clear guidance was documented in the personal plans. Overall the personal planning system was effective in supporting the care and support of residents.

Residents and their representatives were included in the running of the centre, and consulted on a regular basis. Preferences and needs were taken into account and accommodated, and all efforts were made to ensure that the voices of the residents were heard. As the service was currently considering the admission of another resident to the centre, this had been discussed with residents and their families, and their opinion on the matter sought. A transition plan was in place to ensure the least disruption to current residents. Overall the rights of residents were upheld and respected.

Any accidents and incidents, or near misses, were recorded and reported, and a record of any significant issues was escalated to senior management. Records of any incidents included both a description of any incident and a detailed action plan to ensure the prevention of any recurrence of the incident. Where changes in support wee required following an incident, the guidance was clearly detailed in the personal plan, thus ensuring the safeguarding of residents.

A risk register was maintained in which all identified risks, both local and individual, were recorded. In addition there was a detailed risk impact statement in place for each resident. However there was no risk assessment for one aspect of care for a resident, which included a restrictive intervention. Therefore the rational for the use of the intervention, and the information relating to ensuring the use of the least restrictive intervention to mitigate the risk was not available.

There were systems and processes in place in relation to fire safety. All required fire safety equipment was in place and appropriately maintained. There was a personal evacuation plan in place for each resident, which included the level of assistance required in the event of an evacuation, and strategies to encourage the resident to evacuate if required. Fire drills had been undertaken, and the provider had demonstrated that residents were protected form the risk of fire.

There were robust systems in place in relation to the safeguarding of residents. All staff had had appropriate training and there was a policy in place to guide staff. Staff and the person in charge were aware of their roles in relation to safeguarding of residents.

Overall the provider had systems in place to ensure that residents good quality of life, and to ensure that all aspects of their lives were safe and meaningful.

Regulation 10: Communication

Various communication strategies had been introduced to ensure that residents understood information, and that their voices were heard.

Judgment: Compliant

Regulation 11: Visits

Visits were facilitated and welcomed.

Judgment: Compliant

Regulation 17: Premises

The design and layout to the premises was appropriate to meet the needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

Appropriate processes were in place to assess and mitigate identified risks.

Judgment: Compliant

Regulation 27: Protection against infection

Effective measures were in place to ensure protection against infection.

Judgment: Compliant

Regulation 28: Fire precautions

Adequate precautions had been taken against the risk of fire.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place based on an assessment of needs. Plans had been reviewed regularly.

Judgment: Compliant

Regulation 6: Health care

Provision was made for appropriate healthcare.

Judgment: Compliant

Regulation 7: Positive behavioural support

Appropriate systems were in place to respond to behaviours of concern, however there was insufficient evidence that restrictive practices were the least restrictive available to mitigate the associated risk.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to ensure that residents were protected from all forms of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were upheld.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Leaby Lodge OSV-0005366

Inspection ID: MON-0027528

Date of inspection: 08/08/2019

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The centre will continue to be resourced and managed as identified within the Statement of Purpose. Ongoing review of residents' needs and progress will remain the fundamental practice ensuring safe, quality service. All current auditing tools and processes will remain in use to further supplement effective monitoring of service delivery. The service Provider will complete an annual review to ensure senior governance of service provision. Families of the residents will be furnished with a copy of this annual review to allow transparency regarding service provision. Information from the annual review will also be communicated to the residents in an age appropriate manner that best meets their needs. A copy of the annual review will be kept within the centre and will be made available upon request. There is also a date identified for the completion of the annual review of the current year as a follow on from the first annual review.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The centre will continue to assess the behavioural support needs of each resident to ensure their safety through consultation with the residents, their family representatives and input from their Multidisciplinary professionals. This will continue to be implemented within the residents' individual support plans and kept under review. A risk assessment is in place for restrictive practice in use to ensure the safety of the resident which has been completed in consultation and direction of the resident's family representative. Alternative measures to ensure the safety of the resident have been considered and exhausted therefore the use of restrictive practice in this instance will remain.	

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 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	04/10/2019
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	25/09/2019