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:	Laurel Lodge
Name of provider:	Talbot Care Unlimited Company
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	03 September 2024
Centre ID:	OSV-0008169
Fieldwork ID:	MON-0036370

About the designated centre

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

The provider describes Laurel Lodge as providing a residential service for adults both male and female over the age of 18 years with intellectual disabilities, autistic spectrum and/or acquired brain injuries who may also have mental health difficulties and behaviours of concern.
The designated centre is a two storey community house in a rural setting in close proximity to the nearest small town, which accommodates six residents, each having their own bedroom, four of which have en-suite bathrooms. There are two reception rooms and a kitchen/dining room. There is also a communal bathroom and separate W.C and a utility room. The centre is staffed by daytime staff and waking night staff.

The following information outlines some additional data on this centre.

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 (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 3 September 2024	10:30hrs to 17:30hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This inspection was conducted in order to monitor on-going compliance with the regulations, and to help inform the registration renewal decision.

There were six residents on the day of the inspection, although one of them had gone to their family home for a visit. Another resident had a particular dislike of new people, so the inspector did not meet them. This resident chose to limit their face-to-face interactions with people generally, and the person in charge and staff had come up with a way of supporting their choice in this, in that they communicated via text messaging and allowed the resident to initiate any other interactions.

One of the residents was keen to meet the inspector, and invited the inspector to their room. They had their own key to the room, and showed the inspector their tv and play station. They told the inspector about activities that they enjoyed, and said that they made their own choices. They knew who to approach if they had any queries or complaints.

Another resident who returned from an outing during the course of the inspection had a chat with the inspector, and spoke about their outing with enthusiasm. They had been plane spotting, and described the planes coming in to land with excitement. They appeared to have a comfortable relationship with the staff who were supporting them, and had some banter and laughing between them. They mentioned the person in charge by name as someone who supported them and helped them to feel less anxious. They said that 'this house is my home' and they came to the kitchen for coffee and snacks whenever they felt like it, and that they make their own choices.

The inspector conducted a 'walk around' of the centre, and found that it was well maintained and decorated, and had sufficient private and communal areas to support the needs of the residents. Improvements had been made in the premises since the previous inspection in that new external doors had been put into the bedroom of one of the residents whose mobility needs had changed, so that they could be evacuated directly through these doors in the event of an emergency.

There was a spacious and functional outside area, which was furnished and included a pleasant smoking area for residents. The garden was full accessible to residents with mobility issues.

During the inspection the inspector spoke to the person in charge, the person participating in management and two staff members, reviewed documentation and made observations about the daily operation of the designated centre.

Staff had received training in human rights, and spoke about supporting residents to make their own choices and decisions. They explained that where residents were making unwise choices, for example around smoking or unhealthy eating, that they

ensured that information was available to them, so that they were making informed decisions. They spoke about residents having their own money and bank cards, and deciding for themselves what to spend their money on.

Staff were very familiar with the ways in which residents communicate, for example they described how one resident will tap their arm if they want to go back to their room, and how another would run their fingers through their hair if they were happy.

Overall, residents were supported to have a comfortable and meaningful life, with an emphasis on supporting choice and preferences and there was a good standard of care and support in this designated centre.

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

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective both in relation to monitoring practices, and in quality improvement in various areas of care and support.

There was an appropriately qualified and experienced person in charge who was knowledgeable about the support needs of residents and showed clear oversight of the centre, and who was supported by two team leaders.

There was a competent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents. Staff were appropriately supervised both formally and informally.

There was good oversight of any accidents and incidents, and all required notifications were submitted to HIQA within the required timeframe.

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

There were sufficient numbers of staff to meet the needs of residents both day and night, and an appropriate skill mix, including a registered nurse and social care staff. A planned and actual staffing roster was maintained as required by the regulations. There was a consistent staff team who were known to the residents. Where residents required additional staffing, for example for evening activities, this was provided.

The inspector spoke to two staff members, and found that they were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents.

A review of three staff files indicated that all the information required under Schedule 2 of the regulations was in place, included garda vetting, references ad employment history.

Judgment: Compliant

Regulation 16: Training and staff development

All staff training was up-to-date and included training in safeguarding, first aid, fire safety and first aid. There was a clear system of oversight of training records, with an 'outstanding report' that clearly showed when training was due.

Additional training had been provided to staff in relation to the specific support needs of residents, for example, in acquired brain injury and presentations particular to the residents, such as fatigue management.

Day to day supervision was undertaken by the person in charge with the support of two tam leads. Quarterly supervision conversations were held with staff, and the inspector reviewed the records of three of these discussions and found that they were meaningful two way conversations. Staff were given positive feedback, and any actions were agreed. There was shared learning such as a discussion around one of the organisation's policies.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this

structure and their reporting relationships. All required actions identified in the previous inspection of the designated centre had been completed.

Various monitoring and oversight systems were in place. An annual review of the care and support of residents had been prepared in accordance with the regulations. Six-monthly unannounced visits on behalf of the provider had taken place. The reports of these processes indicated a detailed review had taken place. There was a monthly schedule of audits in place, including audits of medication management, care plans and general welfare.

Any required actions identified in the annual review, the six monthly unannounced visits and the audits were all added to a quality improvement plan, and were monitored until complete, by the person in charge and then at monthly management meetings. Actions were identified even where there were no failings in found in the monitoring processes. All identified actions had either been completed or were within their timeframe, for example some improvements had been made to fixtures and fittings, and an additional plan in relation to the support of unsafe behaviour had been developed.

There were regular staff team meetings, and items discussed at these meetings included shared learning from other designated centres operated by the provider, safeguarding, and 'lessons learned'. This item included learning from any accidents and incidents, and a discussion of strategies that were successful, e.g. to continue to do regular checks on the sleep pattern for one resident. In addition there was a written daily handover, which included detailed information about each resident and was also used for daily task allocation.

The monitoring and oversight in the designated centre was effective, and ensured a safe and person centred service.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained all the information required by the regulations, and accurately described the service provided.

Judgment: Compliant

Regulation 31: Notification of incidents

All the required notifications had been submitted to the Chief Inspector in accordance with the regulations, and within the specified timeframes.

Judgment: Compliant

Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. There was an effective personal planning system in place.

Healthcare was effectively monitored and managed, although some improvements were required in one of the care plans. Changing needs were responded to in a timely manner. There was good practice in relation to communication with residents, both in the documentation around communication, and in the innovative ways in which staff were communicating with residents.

Where residents required positive behaviour support, there were detailed assessments and plans in place. Restrictive practices were only in use where they were the least restrictive available strategies to manage the identified risk, and residents had consented to the restrictions.

Residents were safeguarded and protected from any forms of abuse and the person in charge and the staff team were knowledgeable about their role in the protection of vulnerable adults.

Fire safety equipment and practices were in place to ensure the protection of residents from the risks associated with fire, and there was evidence that the residents could be evacuated in a timely manner in the event of an emergency. There were risk management strategies in place, and all identified risks had risk assessments and management plans in place.

The rights of the residents were well supported, and given high priority in the designated centre.

Regulation 10: Communication

Communication with residents was well managed, particularly because some of the residents did not communicate verbally and the first language of others was not English.

Easy-read information had been developed for residents in various aspects of daily life, including making decisions, rights, advocacy and safeguarding. Some residents had access to information about their individual healthcare issues. All residents had access to the internet, and those who chose to had devices such as mobile phones.

Staff were knowledgeable about the communication needs of residents, for example one of the residents who had not long been living in the centre was still exploring ways to communicate. Staff had introduced social stories and pictures, and when these were not altogether successful, had introduced objects of reference. Together with the speech and language therapist they were beginning to introduce sign language, and the resident had learnt their first sign.

Throughout the inspection the inspector observed staff communicating effectively with residents in multiple different ways, and it was clear that communication recognised as being of paramount importance.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were involved in a range of different activities both in their homes and in the community, in accordance with their preferences.

Some residents were members of local groups and clubs, some enjoyed going to local pubs and cafes. Some residents attended the local interactive library and had been on trips to museums and exhibitions.

Most of the residents preferred to plan their activities on a daily basis, and a record was maintained of each residents' activities. These records included information about the resident's response to the activities, whether they engaged in the activity and whether they enjoyed it.

The records and the observations made by the inspector indicated that residents were being supported to have a meaningful day.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a current risk management policy which included all the requirements of the regulations. Risk registers were maintained which included both local and environmental risks, and individual risks to residents. There was a risk assessment and risk management plan for each of the identified risks. Local and environmental risks managed under this system included the staffing levels, infection prevention and control and safeguarding.

Individual risk assessments included the risk relating to a resident declining to engage in personal care, individual fire safety and the risks associated with poor swallow and the risk of aspiration. Each of the identified risks had a detailed risk

management plan outlining the guidance to staff to mitigate the risk. Each of these management plans was regularly reviewed, and staff could describe their role in implementing them.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. There were self-closing fire doors throughout the centre and all equipment had been maintained.

Regular fire drills had been undertaken, and any new staff member took part in a fire drill as part of the indication process. There was an up-to-date personal evacuation plan in place for each resident, giving clear guidance to staff as to how to support each resident to evacuate. Where one of the residents had, on occasion, declined to participate in a fire drill, there was guidance for staff as to how to support them to evacuate in there was an emergency.

All staff had received training in fire safety, and the staff who spoke to the inspector could describe the steps they would take in the event of an emergency that required the evacuation of residents.

Judgment: Compliant

Regulation 6: Health care

Healthcare was well managed and monitored, and there were healthcare plans for any identified healthcare needs that provided detailed guidance for staff for the most part. For example, there was a care plan in relation to the management of a percutaneous endoscopic gastrostomy (PEG) for one of the residents, which included very detailed direction for staff around the care of the PEG, feeding via the PEC and the associated mouth-care.

However, the care plan for the management of epilepsy for another resident was not as clear, it did not give detailed information as to how to manage the resident if they had a seizure, or when they were in recovery. While there was further information in the risk assessment for epilepsy, the care plan did not refer to it. In addition, the guidance in relation to the administration of rescue medication differed in the care plan and the medication protocol. This was rectified during the course of the inspection, and the staff took the protocol to the general practitioner (GP) for sign off on the day. However, the discrepancy had not been identified during any of the processes in place in the centre prior to the inspection.

Residents had ready access to members of the multi-disciplinary team including the GP, psychologist, neurologist and Speech and Language Therapist (SALT). Where residents had changing healthcare needs, the appropriate referrals had been made. For example, where a resident had a deteriorating skin condition, a referral had been made to the skin integrity nurse, and the resident was now awaiting a dermatology appointment.

Residents were being supported in health promotion, for example information about smoking and healthy eating were made available to them. A detailed vaccination record was maintained for each resident.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where residents required positive behaviour support, there were detailed plans in place, based on a detailed assessment of needs. There was step by step guidance in these plans as to how staff should respond to various presentations of residents. Information included the identification of gestures or behaviours from residents which might indicate that staff should disengage, for example a fake yawn' had been identified as being a sign of discomfort for one of the residents.

Any restrictive practices which had been found to be necessary to ensure the safety of residents were based on a detailed assessment, and information had been made available to residents and their consent sought for any restrictions.

Where physical interventions might be required as a last resort, there was a 'supporting unsafe behaviour' plan with very detailed guidance for staff, including photographs of the correct sage of any techniques that might be required. Staff could describe these techniques, and were very clear that they should only ever be used as a last resort.

A log of restrictive practices was maintained, which clearly identified any restriction, and there was quarterly oversight of all interventions by the 'restrictive practices review committee'.

Judgment: Compliant

Regulation 8: Protection

There was a clear safeguarding policy, and all staff were aware of the content of this policy, and knew their responsibilities in relation to safeguarding residents. Staff were in receipt of up-to-date training in safeguarding, and could discuss the learning from this training and describe their role in protecting residents from all forms of

abuse.

Where safeguarding issues had been identified there were clear and detailed safeguarding plans in place which outlined the measures to be taken to mitigate any risks to residents. Appropriate measures had been taken to ensure the safety of all residents. The person in charge was very familiar with her role in the safeguarding of residents, and discussed any safeguarding issues in with staff at the regular staff meetings.

Judgment: Compliant

Regulation 9: Residents' rights

All staff and the person in charge had received training in human rights and in assisted decision making. They spoke about the importance of ensuring that meaningful choices were offered to residents, and the importance of effective communication in order to ensure that residents both understood their rights, and that they made their own decisions and choices.

Weekly residents' meetings were held, and the records of these meetings indicated that they were a meaningful discussion, and the input of each resident was noted. Information was made available in easy-read versions and in the language of residents whose first language was not English. Some residents chose not to attend these meetings, so consultation took place with them on an individual basis.

Residents had access to an independent advocacy service, and one of the residents was currently availing of this service and had a meeting with their advocate in the week of the inspection. Another resident has a decision making assistant.

It was clear throughout the inspection that the rights of residents were given high priority and that their voices were heard.

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 (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 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Laurel Lodge OSV-0008169

Inspection ID: MON-0036370

Date of inspection: 03/09/2024

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 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: The Care plan has been reviewed and updated to include all information identified in the corresponding risk assessment and includes a step by step guide for staff to support residents in the event of a seizure and throughout the recovery process. All staff have completed training in supporting a person with epilepsy including the recovery process. On the day of the inspection, protocol for rescue medication was reviewed and updated by the nursing staff to align with the epilepsy care plan and has been signed by the GP. The Person in Charge has completed an overview of all resident's care plans to ensure sufficient information to support resident's needs and maintain consistency between care plans and medication protocols. Although monthly audits had been conducted and actions identified, the Person in Charge and Nursing staff will now ensure more vigilance in oversight of steps outlined in care plans. The Assistant Director will also monitor closely during monthly governance. The Person in Charge has discussed with all staff members during recent team meetings/supervision where necessary, to ensure that clear guidance is provided in all residents' care plans and discussed with nursing staff when updating plans. Updated plans have been shared with the entire team.	

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 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/10/2024