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:	Lime Lodge Residential Service
Name of provider:	RehabCare
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	06 December 2021
Centre ID:	OSV-0005891
Fieldwork ID:	MON-0027145

About the designated centre

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

Lime Lodge Residential Service is a bungalow type house located on the grounds of day service run by the provider on the outskirts of a town. The centre can provide for a maximum of two residents of both genders and those with mild intellectual disabilities, high functioning Autism Spectrum Disorder and mental health needs between the ages of 18 and 65. The designated centre provides a residential service from Monday to Friday only. Within the centre there are two resident bedrooms, three bathrooms, a staff office/sleepover room, two leisure rooms, a dining area, a kitchen and a communal lounge. Staff support is provided by the person in charge, a team leader and care workers.

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
Monday 6 December 2021	9:25 am to 6:00 pm	Caitriona Twomey	Lead

What residents told us and what inspectors observed

Residents in the centre were supported have a good quality of life and received a highly-personalised service. Residents were engaged in a wide variety of activities linked to their personal preferences and goals. Residents' rights and independence were central to the service provided. Improvements were required in the implementation of the provider's own policies especially in regard to medication management in the centre.

This was an announced inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

On arrival, the inspector met with the team leader and the person in charge. Both were recently appointed to these roles. At the time of the last HIQA (Health Information and Quality Authority) inspection there was only one resident living in this centre. A second resident moved in in September 2021. Staff reported that this move had gone very well and that both residents had a number of shared interests. The residents knew each other prior to living together as they had both attended the same day service. The centre changed from providing a five to a seven days a week service when the second resident moved in. As a result the resident who had previously gone to their family home at the weekends was now occasionally staying in the centre all week. They told the inspector that this was something they really enjoyed and looked forward to doing more. The addition of a second resident also meant additional staff. At this time a longstanding member of staff left the team. These events resulted in a lot of changes for the original resident of the centre. Staff spoke about the importance of routine for this person and were aware of how challenging this period of change was, and at times continued to be, for them.

The centre was a three bedroom, single storey house on a campus run by the provider on the outskirts of a coastal town in county Cork. A day service was also located on this campus. One resident attended the day service from Monday to Friday. The other resident attended regularly in line with their interests and other activities.

The inspector was shown around the centre by one of the residents. They described to the inspector how important safety is to them and the checks they do every day. Areas of the premises that required maintenance were highlighted by the resident. This included two areas on the ceiling where damp was evident. Management advised that a temporary measure had been put in place and more effective works were scheduled for that week. The resident confirmed this information.

Each resident had their own bedroom, bathroom, and living area. One resident told the inspector that they do not like the shower and would prefer a bath. This information was passed on to management for their consideration. There was a large communal living area in the the middle of the centre. This had a large

television and bookshelves filled with puzzles, art materials, books, photographs, games and DVDs reflective of the residents' interests. There was a notice board near the front door with information on display. The resident referred the inspector to this when talking about the staff team and who was working there that day. There was another notice board in the kitchen that displayed information about activities, including the schedule for local adult education classes. The resident told the inspector about a conversational Irish class they will planned to join in the new year. The kitchen was clean and well equipped. Each resident had their own fridge and there was a separate one for staff. There was a separate laundry room in the centre. The inspector could see the systems in place to support infection prevention and control when dealing with residents' and household laundry. It was noted that some of the cupboards in this room were locked. This restriction had not been reported to HIQA as is required by the regulations and the provider's own policy.

While showing the inspector around the centre, a resident spoke about why they liked living there. They mentioned several activities and highlighted 'culture night'. Staff later explained that these were events held in the centre that gave residents and staff the opportunity to engage in activities and eat foods associated with different cultures. There had already been culture nights about Italy, France and Mexico and nights were planned regarding Irish and African culture. This resident had a wide variety of interests and staff supported them to maintain and further develop these. The resident was a member of the local library and had books on physics, the French language, and general knowledge in their bedroom. They were very knowledgeable on these topics and were happy to discuss them with the inspector. The resident also mentioned the activities of daily living that they participated in such as shopping, cooking and cleaning. The resident had a very good understanding of their finances and the costs associated with living in the centre.

Family contact was very important to the residents living in the centre and their relatives. One resident had visited their family home the day prior to this inspection. They spoke about meeting various members of their family and how much they enjoyed it. At the time of this inspection the other resident had not yet returned from spending the weekend in their family home. They came back to the centre as feedback at the close of the inspection was due to begin. As there was no opportunity to meet on that day the inspector arranged to speak with this resident the following day on the telephone.

When speaking with the inspector this resident expressed that they were happy living in the centre. They made reference to the fact that 'things had changed'. It was clear that this resident was still adapting to these changes. They spoke about supports that had been put in place to help them with this and told the inspector that they were happy and felt safe now. However, later in the same conversation the resident spoke about how they were feeling. When asked if they had spoken to staff about this the resident said 'they know I'm sure'. The inspector encouraged this resident to raise these matters with staff again and advised that they would also do this. These matters had been brought to the inspector's attention during the inspection by the management team and were the subject of open complaints.

The resident went on to speak about the various activities they participate in and what they like about the centre, including walking into town and going for a coffee. They were positive about the staff team and the opportunities they now had to spend weekends in the centre. They spoke about enjoyable shared activities such as culture nights and going hiking. They told the inspector of their life ambition to write a children's book and how they planned to do some writing that day. They also spoke about a calendar made with photographs they had taken. The resident had designed, printed and sold the calendar in the local area. The inspector had seen reference to this the previous day in the resident's person centred plan. The resident was independent in many areas of their life and spoke in some detail with the inspector about meals they liked to cook, sharing a recipe for French toast. They expressed a wish to 'get a takeaway the odd time'. The resident planned to discuss this with staff.

As this was an announced inspection, resident questionnaires were sent to the provider in advance. One was completed by each resident of the centre. Overall the feedback received was very positive and reflective of what the inspector had been told and observed during the inspection. One resident had provided a neutral response to three questions, aside from those, all responses were positive in both questionnaires.

Surveys were completed by the provider each year regarding the service provided. Both residents and their families were invited to participate. The inspector reviewed the most recently completed surveys. One family member described the centre as a lovely comfortable space where they, as a family, felt very welcome. They described the 'great assistance' provided by staff who they also described as 'very considerate and clear'. Relatives of the other resident were also positive in their feedback. The person in charge had followed up on any areas identified as requiring improvement in these surveys and a meeting was held to assure relatives that actions were being taken.

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 on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

Overall, good management practices were seen, the provider adequately resourced and staffed the service, and it collected information in order to improve the quality of life of residents. Some improvement was required in oversight to ensure the implementation of the provider's own policies, especially regarding medication management.

There was a clearly-defined management structure in place that ensured that staff were aware of their responsibilities and who they were accountable to. The team

leader was in this role since September 2021. They told the inspector this was a temporary arrangement as the former team leader was on extended leave. They worked in the centre three days a week. The team leader reported to the person in charge. The person in charge fulfilled this role for one other designated centre based on the same campus. They reported to the person participating in management.

As outlined in the opening section of this report, there had been some changes to the staff team through the addition of new staff and one leaving the team. At the time of this inspection there was a regular team supporting the residents. This continuity of care was very important to the residents. The inspector reviewed staff training records. Some gaps were identified. It was explained to the inspector that this was due to a decision by the provider not to run certain in-person training during the COVID-19 pandemic. The person in charge spoke with the inspector about autism training that they planned to organise in the new year.

An annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as is required by the regulations. The annual review was completed in July 2021 when there was only one resident living in the centre. This review involved consultation with the resident and this informed the action plan. There was evidence that these actions had been completed. The most recent unannounced visit had taken place in the month prior to this inspection. The person in charge was aware of the action plan and there was evidence that this was being progressed.

A number of audits had been completed in the centre by the team leader. When reviewing the most recent medication audit, the inspector identified a number of issues regarding the medication management practices in the centre. As the audit had not been completed in full, these issues had not been identified by the provider. Support and training was required to ensure that staff were equipped with the knowledge and expertise to complete these audits. Further clarity was also required regarding 'as needed' medications and what condition they were prescribed and administered to treat. The findings regarding medication management will be discussed in more detail in the next section of this report.

The inspector reviewed the complaints log in the centre. Some of the feedback received as part of the annual review had been classified and responded to as complaints. Some complaints were still open at the time of this inspection. The inspector noted that each complaint had been responded to and appropriate actions taken. It was identified that improvement was required in documenting the actions taken and also in assessing and making note of the satisfaction of the complainant. The person in charge developed a template to record this information during the inspection.

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service provided, the resident profile, the ethos and governance arrangements and the staffing arrangements. This document had been recently reviewed and included all

of the information required by the regulations.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of this centre in line with the requirements outlined in this regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and had the skills, qualifications and experience necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The number, qualifications and skill-mix of the staff team was appropriate to the number and assessed needs of the residents living in the designated centre. There was a planned and actual staff rota in place and evidence of a continuity of care and support. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Two staff required training in fire safety and one in the management of behaviour that is challenging including de-escalation and intervention techniques. At the time of this inspection these were not planned.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents was well maintained in the centre and included all of the information required by this regulation.

Judgment: Compliant

Regulation 23: Governance and management

Improvement was required in the knowledge, oversight and implementation of the provider's medication management policy in the centre to ensure residents' safety in this area.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Signed service and tenancy agreements were in place for both residents of the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The centre's statement of purpose had recently been reviewed and included all of the information required by this regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

All adverse incidents as specified in this regulation had been submitted to HIQA, as required. However, locked cupboards in the centre had not been reported as a restrictive practice.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Records required improvement to ensure that the actions taken on foot of a complaint and the satisfaction of complainants was always noted.

Judgment: Substantially compliant

Quality and safety

The residents living in this centre were independent in many areas of their lives and had a wide a variety of interests. They enjoyed living in the centre and received a good quality service, personalised to their individual needs. This ensured that each resident's wellbeing was promoted at all times, that independence and community involvement was encouraged, and that residents were kept safe. There was one notable exception to this. Significant improvement was required in the medication management practices in the centre to ensure residents' safety and wellbeing.

Residents were regularly consulted with about, and were actively involved in, the running of the centre. Both residents spoke with the inspector about 'Monday meetings'. These were one-to-one meetings held weekly to plan both routine (such as shopping and day service attendance) and other activities (such as attending Christmas markets) and to discuss other matters important to the residents. House meetings where both residents attended had also occurred but not regularly. The person in charge explained that it was planned for more of these meetings to take place.

Residents had a wide variety of interests. One resident was very creative and the range of activities they participated in reflected this side of their personality. They were learning an instrument, had created a calendar using photographs they had taken and were hoping to write and publish a children's book. The other resident also had a range of interests including languages, science and technology. There was evidence throughout the inspection that residents were supported to continue to enjoy and to further develop these interests in the centre, in day services and in their local community.

The inspector reviewed residents' individual files. These were comprehensive and reflective of the information shared with the inspector by residents and staff in the course of this inspection. Residents' personal histories, abilities and interests were documented. Healthcare needs were also included. There was evidence that residents were supported to attend their general practitioners and other medical specialists, as required. The files contained a number of plans outlining how staff could best support each resident in various aspects of their daily life. They also documented the many areas in which the residents were independent. However a multidisciplinary review of residents' plans had not taken place, as is required by the

regulations. Both residents in the centre regularly received support from local mental health services. Residents attended these appointments independently. Staff in the centre had not received input from these professionals in how best to support the residents with their mental health. When speaking with the inspector, both residents had expressed how important it was to them so maintain good mental health.

One resident required a behaviour support plan. The inspector reviewed documentation which showed this specialist input had been requested by the person in charge in June 2021, three months prior to the resident moving in. At the time of this inspection, in December 2021, no supports had been received. The person in charge advised that a meeting was due to take place that week. The delay in receiving these supports had a negative impact on both the resident involved and their housemate. Another resident was also on a waiting list for supports from the provider's psychology service. It was outlined in documentation reviewed that this support was to be provided in September 2021 but at the time of this inspection it was still outstanding.

Each resident had a personal development plan outlining what was important to them and the goals they would like to achieve in the coming year. These were developed by the resident in consultation with staff in the designated centre and their day service. The person in charge outlined how residents' personal development plans were documented in the centre. The inspector was shown a series of poster size pages. These documented the planning process and the development of goals in an accessible way that was meaningful to the resident. Goals were then documented in residents' files for the purposes of monitoring and review. There was evidence on the day of the inspection of progress made in respect of each resident's goals, for example, the development and sale of a calendar. However, this progress was not always documented in residents' files.

Both residents administered their own medication. Staff may remind or prompt them to do this. The inspector viewed assessments completed regarding self-administration. Each resident had a locked cupboard in their bedroom to store their medication. The team leader explained the processes in place regarding the return of medication to the pharmacy, as needed. One resident spoke with the inspector about their medications and had a very good knowledge of each one and when they took them. It was noted that there had been a number of medication errors in the centre. Many of these related to tablets being dropped. In response to this identified issue, the team leader discussed this with the resident in question and together they developed a support plan for both staff and the resident. This ensured that the resident was involved in, and comfortable with, the support provided to them. The plan had proved effective in reducing the number of errors.

When discussing medication practices in the centre it became clear that the provider's own policies were not being implemented. Although residents' routine medications were provided in blister packs other PRN or 'as needed' medications were not. There were no counts or audits being completed of these medications. This was not consistent with the provider's policy. The inspector was informed that staff checked the contents of blister packs weekly when they were brought into the

centre. The inspector saw documents indicating that these checks had taken place. However when they asked to see the prescriptions referenced in these checks, it was identified that the documentation available did not meet the requirements of the provider's own policy. This documentation did not specify the maximum dose in 24 hours of 'as needed medications', not all 'as needed' medications were identified as such, it was not documented that some medications had been discontinued, and the frequency at which one medication was to be administered was not noted. It was therefore concluded that the weekly checks completed by staff could not be accurate as the documents they were cross referencing were not accurate. Improvement was required to ensure residents could be safely supported to continue administering their medications.

The inspector also reviewed the plans and guidelines in place regarding the administration of prescribed PRN or 'as needed' medications. These had not been reviewed in the previous 12 months, as required.The team leader advised that updated guidelines had been sent to residents' doctors for approval. The information included on these documents was not consistent with staff practices in the centre and therefore required further review. One resident was prescribed a psychotropic medication to be taken as needed. Staff advised that administration of this medication had not been reported to HIQA as its use was not considered a restraint or restrictive practice. However staff were not clear what medical condition this medication was prescribed to treat. No mental health diagnosis or condition was documented in the resident's individual file or in the centre's directory of residents. As it was not documented what medical condition this medication was prescribed to treat, it was not clear how it had been concluded that administration of this medication was not a restriction.

The centre was warm, clean and decorated in a homely manner. Some minor maintenance works were required and these were planned. As outlined in the opening section of this report, locked cupboards in the laundry area had not been identified as restrictive practices. Management planned to review whether this restriction was necessary and if so committed to implementing the provider's policy.

The inspector reviewed the centre's risk register. Although comprehensive, the ratings required review to ensure that they were reflective of the actual risks posed by identified hazards. For example, the ratings regarding the impact of a resident engaging in behaviours that challenge or contracting COVID-19 were not accurate.

An infection prevention and control (IPC) audit had been completed in the centre. Systems were in place for the routine monitoring of staff and residents for any possible symptoms of COVID-19. Contingency plans were in place and were specific to the centre. The staff team had successfully supported one resident to isolate in the centre. The layout of the building facilitated this. A room had been identified should staff become symptomatic while working in the centre. Staff were observed engaging in enhanced IPC throughout this inspection and it was noted that suitable supplies and equipment were available.

Systems were in place and effective for the maintenance of fire detection and alarm systems, including emergency lighting. One of the residents reliably informed the

inspector that the fire extinguishers had last been serviced in February 2021. Each resident had a recently reviewed personal emergency evacuation plan (PEEP). Regular evacuation drills had taken place in the centre with different scenarios. It was noted that no drill had been completed in the centre that year when both residents were in the house with night-time staffing levels. The person in charge committed to completing such a drill in the near future.

One resident had moved into the centre three months prior to this inspection. The inspector reviewed the documents outlining the assessment process undertaken prior to this move and the transition plan that was implemented. A compatibility assessment regarding the two residents living together was also completed. As part of their move into the centre, the resident had been supported to develop an easy-to-read document about themselves to share with their new housemate. Staff reported that this was very well received.

Regulation 10: Communication

Staff at a very good understanding residents' individual communication needs and preferences. There was wireless Internet available throughout the centre. Television, radio and local newspapers were available.

Judgment: Compliant

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had access to and retained control of their personal property and possessions. There was adequate space and storage in each resident's bedroom and personal living space to store their belongings.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access to many opportunities and facilities for occupation, recreation, education and training. Both residents participated in a variety of activities in line with their interests in the centre and their wider community.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre met the needs of the residents. While clean, comfortable and decorated in a homely manner, there were some maintenance issues that needed to be addressed. These works were planned,.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The kitchen was stocked with a variety of fresh and nutritious food. Suitable storage was available and choice was provided in line with residents' preferences.

Judgment: Compliant

Regulation 20: Information for residents

The guide prepared for residents required review to ensure that it contained the most up-to-date information throughout the document, including that a seven day service is now provided and the name of the current person in charge.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

A thorough gathering of information and assessment was completed to support the transition of one resident to the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The scoring of risk assessments required review to ensure that they were reflective of the risk posed by identified hazards in the centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare associated infections including COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

Although regular fire evacuation drills had been undertaken, the person in charge confirmed they had not completed a drill that year with minimum staffing levels or in a night-time scenario.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Not all of the appropriate and suitable practices and documentation as outlined in the provider's own policy regarding the receipt, prescribing and administration of medicines were implemented in the centre. Up to date prescriptions with the required information were not available. As a result the accuracy of the additional safety measures in place to support residents to self-administer their medications could not be ensured. Medication counts of 'as needed' medications were also not completed in the centre, as required by the provider's policy.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment that resulted in the development of a personal plan. However a multidisciplinary review of residents' personal plans had not taken place. It was also identified that not all plans had been reviewed in the previous 12 months, as required. Improvement was also required in documenting the review and progress achieved in residents' personal planning goals.

Judgment: Substantially compliant

Regulation 6: Health care

Appropriate healthcare was provided to residents in line with their personal plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

Despite requests, an assessment to identify the cause, and a plan to reduce the likelihood and impact, of behaviours that are challenging was not in place. As a result staff did not have up to date knowledge to support and respond to such incidents. The person in charge advised that this process was scheduled to begin in the week of this inspection.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding concerns had been addressed in line with the provider's and national policy. Both residents had an intimate and personal care plan in place that considered their dignity and areas of independence. All staff had received training in relation to safeguarding residents and the prevention, detection, and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported and encouraged to be involved in the running of the

centre and the service provided to them. Residents were supported to understand their rights and to exercise them.
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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially 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 Lime Lodge Residential Service OSV-0005891

Inspection ID: MON-0027145

Date of inspection: 06/12/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • PIC has requested face to face MAPA training for two staff that require it, due to current high COVID levels date has yet to be confirmed. All staff have completed fire safety, 2 staff member are awaiting fire warden safety. The above will be completed by 28/02/2022.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: PIC and Team Leader will complete a monthly service audit which will include a review of medication counts, documents and incidents. This will be completed on a monthly basis from January 2022.	

Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • Restrictive Practice no longer in place, press doors in utility room are now unlocked, with the exception of cleaning cupboard, it is locked after each use. A key has been left in the utility room so both staff and residents can open it when required. This was completed on 07/12/2021.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • New Template has been developed to support existing paperwork and provide more step by step detail on how the complaint was resolved. The new template requires a signature from the person who made the complaint to clarify they are happy that the problem has been resolved, this will be recorded on the Provider's Complaint Management Database. This action was completed on 06/12/2021.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Roof has been fixed, area now needs to be painted. This will be completed by 26/01/2021. • Pressure pump has been installed on showers, electrics to be completed by 26/01/2022	
Regulation 20: Information for residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 20: Information for residents: • Service Guide to be updated with new PIC name and reflect current number of residents in the service this will be completed by 15/01/22.	

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• PIC and Team leader reviewed the Risk Assessments at individual and service level to ensure that the correct rating is applied to reflect the risk posed, this was completed by 06/01/2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire Drill has been completed in the early morning with one staff member and two residents to reflect night time staffing, evacuation was successful and no issues were identified. This was completed on 06/01/2022.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All medication is now individually counted when it comes into the service and documented on the medication count form. This has been implemented since 07/12/2021.
• Enhanced PRN Protocols have been developed in consultation with the GP, this was completed by 10/12/2021.
• Renewed prescription has been received for one resident and is currently awaited for the other, this will be completed by 17/01/2022.
• PIC has sought advice from the Rehab Group Medication Management Lead in respect of issues raised in this report and implemented actions advised.
• Updates to the Local medication procedure has been complete. Updates to the Residents Individual Medication Management plans and support plans around their medications have been completed.
• All staff have been provided with one to one guidance by the Team Leader on how to count in and out medication and document same.
• Medication policy was discussed at Team Meetings on 17/12/2021.

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Team Leader will set up an MDT Review meeting for each resident and will request input from GPs, Mental health support team and Behavioral Therapist. This will be completed by 30/01/2022.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Behavioral Therapist has been consulted, currently ABC reports to track behaviors are being completed by staff team. BT is also linking in with staff during staff meeting to gather information on behavioral presentation. Behaviour support plan will then be developed based on the information gathered, this will be completed 28/02/2022.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	28/02/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	26/01/2022
Regulation 20(2)(a)	The guide prepared under paragraph (1) shall include a summary of the services and facilities provided.	Substantially Compliant	Yellow	15/01/2022
Regulation 23(1)(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	31/01/2022

	management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	06/01/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	04/01/2022
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering,	Not Compliant	Orange	17/01/2022

	receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 31(1)(a)	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: the unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre.	Substantially Compliant	Yellow	07/12/2021
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	06/12/2021
Regulation	The person in	Substantially	Yellow	30/01/2022

05(6)(a)	charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Compliant		
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/01/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	28/02/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation	Substantially Compliant	Yellow	28/02/2022

	every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			