

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004924
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Limited
Provider Nominee:	Brian Gallagher
Lead inspector:	Linda Moore
Support inspector(s):	Shane Walsh
Type of inspection	Announced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
21 April 2015 09:30	21 April 2015 20:30
22 April 2015 08:00	22 April 2015 19:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This registration monitoring inspection of Cheeverstown House Residential Services was announced and took place over two days. As part of the inspection, the inspector met with residents, relatives and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. The inspector received questionnaires from residents and relatives which were complimentary of the service being provided at the centre. However the areas for improvement identified were the communication and follow through on information received.

Throughout the inspection, the inspector found that there were a significant number of areas of non-compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (children and adults) with disabilities) Regulations 2013.

The inspector found that residents were not fully protected from all forms of abuse. There was a policy protecting residents' property and monies; however this was not implemented in practice.

There was a lack of clinical governance in the centre which resulted in poor outcomes for residents. There was no nominated person in charge as required by the Regulations.

Due to the routine practice in the centre, residents were not supported to maintain choice in their daily life. The resident's day was seen to be centred around the availability of staff and the access to the day service and was not based on their needs or their personal plans.

Due to the size and layout of the multi occupancy bedrooms and bathrooms, dignity and privacy for all residents could not be maintained. An annual report of the quality and safety of care and support in the designated centre was not available. The Statement of Purpose did not fully meet the requirements of the Regulations.

Other areas for improvement included the development and implementation of residents' personal plans, implementation of the risk management policies to guide staff practices, the complaints procedures and the contract for provision of services.

The inspector found that residents were supported to develop and maintain personal relationships and links with their family and they were encouraged and welcomed to be involved in the lives of residents. There were appropriate arrangements in place to support residents' health care issues as they arose. However follow through on referrals was not consistent.

There was some evidence that residents and relatives have an opportunity to contribute in how the centre is planned and run through family members.

Inspectors found that the provider had addressed four of the areas of non-compliance that had been identified on the previous inspection. These related to medication management. Two actions were partly addressed; however 16 actions had not been addressed.

The non compliances are discussed in the body of the report and included in the action plan at the end of this report.

The provider submitted two versions of an action plan response however, both did not fully address some of the non compliances, and therefore some of the action plan responses were not accepted by the Authority.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspector found that due to the layout of the premises, resident's rights and dignity were not well maintained. The inspector also noted that due to the routine practice in the centre, residents were not supported to maintain choice in their daily life. Activities are dictated by the routine and resources of the centre and not by the wishes of the residents.

There was some evidence that residents and relatives have an opportunity to contribute in how the centre is planned and run. The inspector found that resident's wishes were progressed to board level through the parents on the board of the centre.

Some residents could give some examples of how they were involved in the running of the centre – for example, deciding on their own meals.

Some of the staff spoke about resident's involvement with their local community including trips to the supermarket, visiting family members, going to the local shops and going out for a meal with support.

The inspector found that the complaints policy met the requirements of the regulations; however this was not on display in the designated centre. Relatives were not fully familiar with whom they could make a complaint, but they did describe how the staff were available if needed. There were no complaints made available for review for the service. Information on how to contact an external advocate was on display, however staff who supported residents were not familiar with this person or how to access the service.

During inspection, many of the staff were seen to treat residents with dignity and respect, however this was not always the case. This was discussed with the provider during the inspection. Due to the structure of the day, care was routine and not person centred. The resident's day was seen to be centred around the availability of staff and the access to the day service and was not based on their needs or their personal plans. One relative told inspectors that the resident was placed in night clothes at seven pm, due to the staff number in the house. This was confirmed by talking to staff.

Many of the staff spoke of lack of staffing attributing to the residents lack of access to activities that are meaningful and purposeful and reflected their interests and capacities. Residents who accessed the respite service could not go out as a group due to the number of residents who required one to one assistance with their wheelchairs. This had not been considered during the admission process.

Due to the size and layout of the multi occupancy bedrooms and bathrooms, dignity and privacy for all residents could not be maintained. Staff described that with the multi functional bathrooms residents used a toilet in a cubicle while other residents had a shower behind a curtain in the same room. See outcome 6.

Support plans showed that staff facilitated residents to exercise religious rights. Residents were supported to access mass in the local church.

There was a policy protecting residents' property and monies, however this was not implemented in practice. Staff support residents to retain control over their property and where small amounts of monies are held by the centre there is transparent procedures around this to protect both residents and staff. However, they were not effective in practice. Residents did not have a bank account in their own name, and residents' monies such as pensions or disability allowance were paid directly into a centralised bank account belonging to the organisation. This was an action from the previous inspection and was not addressed.

The inspector found that residents' finances were not fully managed in accordance with the policy. Balances were checked and were incorrect for two residents. Staff utilised residents' monies at times for activity not related to this resident in one house. The inspector found that all entries were not always signed by two staff members or the resident.

Judgment:

Non Compliant - Major

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found that many of the staff responded very effectively to the communication support needs of residents. However there were areas for improvement.

Relevant information was available throughout the centre in accessible formats. For example, menu choices were available in picture format to support residents making a choice. This was not consistently on display. While residents had communication passports, they were not consistently updated for all residents to include their current needs. The communication passports were stored with the secure file and was not been used by staff to interact with residents.

Residents had access to magazines, radio, TV, and telephone. However internet access was not provided to residents to enhance their communication. One resident could not always access the telephone to take a call from family as the staff could not leave the other residents to support the resident with the phone call.

While one assistive devices assessment was completed, these were not consistently completed for all residents with communication difficulties. Staff said that a laptop had been purchased for a resident. This was not available in the centre at the time of the inspection. Other assistive technology or aids and appliances were not available for any resident to support their communication needs and promote their full capabilities.

Judgment:

Substantially Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found that residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.

There were relatives visiting at the time of the inspection. Relatives told the inspector that family members and friends could visit at any time and some residents said that they visited their family home regularly. Residents were supported to maintain friendships with those they knew in the other houses where they lived.

While staff and relatives told the inspector that family were very involved in the residents' annual assessment goal setting, there was no documented evidence of this participation.

Both residents and staff confirmed that space was made available to meet a visitor in private; they could use the resident's bedroom, the office or the sitting room if this was free at the time.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector reviewed and found that the admissions policy only briefly set out the arrangements for admitting new residents to the centre. The procedure for the use of the respite house was not fully included in the policy. See outcome 18.

The inspector found that the respite house was only used sixty percent of the year, therefore there was no current assessment of resident completed on admission and the personal plans were written by the day services or school, and they did not guide the care in the service. The inspector was informed by the staff that a resident was allergic to peanuts, while a parent had written this to the service, all staff who prepared meals for residents were not aware of the resident's specific needs and there was no care plan to guide the care for this resident.

The inspector found that one child resided in an adult service. While there did not appear to be any negative outcome for the child, there was no risk assessment to identify the risk and control measures to guide staff. The director of care stated that there was a plan to move this resident to an appropriate location; however, this was dependent on the funding available.

There was a contract of care in place to detail the supports, care and welfare of the residents in the designated centre. This was called the memo of service provision. This was supported by a "manage my money" document. However the contract of care did not fully include the details of the services to be provided for that resident. The inspector found that many of these agreements had not been signed.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The residents had a personal plan and the inspector reviewed a sample of seven of the plans. Significant work had taken place in one area to improve the documentation. However, there was not a consistent approach to the development of the plans. The current model of personal plans did not support the development of current needs and choices of all residents. The personal plans were not all available in an accessible format and the resident was not involved in their development.

The assessment did not have multidisciplinary input, there was no assessment of need and therefore this did not inform the personal plans. Many of the staff spoken with were not aware of the residents' plans and they did not inform the service delivered. There was some evidence of reviews, however, it was not apparent if the goals set had been realised. The provider had acknowledged the deficits in the documentation and had recently introduced a new planning document and staff had received training. The inspector found that when this was introduced it would address many of the deficits identified.

The personal plans contained important information such as details of family members and other people who are important in their lives and information regarding residents' interests. The inspector found that there were no individualised risk assessments completed for residents to ensure continued safety of residents, for example, residents

who required specific medical interventions. The inspector also found that there was a lack of care plans to guide the care to residents, see outcome 11.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspector found that the physical environment in the centre did not meet the requirements of the Regulations. There were significant deficits noted which impacted on the rights and dignity of residents. There were an insufficient number of showers and toilets to meet residents' needs and the multi occupancy rooms did not maintain residents' dignity.

While these issues had been discussed at the property committee, there was no plan as yet in place to address the deficits in the premises.

The centre consisted of four houses, three are located on the campus close to each other and the other is a 15 minute drive away.

The first house is a two storey building in the community and consists of six single bedrooms for four residents and an office space. One of these bedrooms was used by the sleep over staff. Two of the bedrooms have an en suite. One of these is only suitable for an independent resident, due to the size and layout of the room. There are an insufficient number of toilets and showers – residents used the en suite of a resident who was in hospital to facilitate them to have a shower. Other facilities included a separate kitchen, dining area with accessibility to the back garden area and a separate sitting room and a relaxation room. There is one bathroom, which contained a shower, toilet and sink. Inspectors who visited this location observed that mops were left outside as there was no other storage space available. The back garden was not fully secure; inspectors observed a gap in the side gate and this was being closed with a piece of wood. Oxygen was stored on the floor and not maintained safely.

The second house on campus had four bedrooms to accommodate up to nine residents. The provider only used five of these places; there were four residents in the centre during the inspection. There were two multi occupancy bedrooms which did not meet

the need of the residents and did not maintain residents' dignity. One of these consisted of four beds and another was a three bedded room. There is a separate kitchen cum dining room, large day room and a relaxation room.

As already discussed in Outcome 1 the multi-occupancy rooms were not suitable in terms of personal space and the privacy and dignity of residents. In order to reach the beds at the rear of the room it was necessary to walk right past residents' beds located beside the door and through their personal space. One of the residents' beds was located beside the wall; staff moved the bed out to facilitate safe manual handling practices.

There were an insufficient number of toilets for residents needs. There was only one room which housed a shower, two toilets, sluice, washer and dryer. Inspectors asked the staff what occurs if a resident is bathing or showering and another resident needs to use the bathroom. Responses were not consistent; some staff informed inspectors that a curtain would be pulled around the resident bathing or showering to allow the toilets to be used, while others stated the door was locked so residents would need to wait outside. This was not meeting the needs of the residents in terms of privacy and dignity, for those bathing/showering and for those wishing to use the toilet. It was also noted that the washing machine and dryer were located in this bathroom, posing further issues with the accessibility and availability of the toilets/ bathing facilities. While a communal court yard garden was available for residents to use, there was no accessible secure garden in this house.

Houses were noted to have suitable levels of natural and artificial lighting, heating and ventilation.

There were no sluicing facilities available in any of the houses visited.

The third house was on campus and consisted of four single bedrooms. Each room was suitably decorated to meet residents' needs. There was a sitting room, small kitchen and small dining room. The garden was in a poor state of repair, with broken furniture accessible to residents. The main bathroom consisted of a bath, and the pipes were exposed which posed a scald risk to residents. While there was a Jacuzzi bath, there were no handles on the bath to aid residents to access the bath without the risk of injury. A separate toilet and shower room was available.

There were no curtains on one of the residents' bedroom window and the staff said the resident would have difficulty sleeping in the room.

A separate laundry room was in this house, it also contained a toilet and a sluice sink which according to staff was too small for the needs of residents. The toilet in this room was used by residents. There was a stool in the kitchen and the inspector saw that the back of this stool was torn, this was covered with black masking tape. The kitchen had a glass surround and a locked door, completely isolating it from the dining area and which resulted in a reduced sense of homeliness in the dining area.

The fourth house where six residents lived was on the campus, this had capacity for seven residents. The management had relocated one of the residents following the previous inspection and according to staff, this had reduced the instances of behaviour that challenges among residents. One of the residents had their own staff during the

inspection due to their medical needs, and another resident was at home. There was a small kitchen and small dining room, the kitchen was locked to maintain residents' safety. The kitchen had a glass surround and a locked door, completely isolating it from the dining area and which resulted in a reduced sense of homeliness in the dining area. There was one bathroom which housed the washer, dryer and two toilets, a chair lift bath and shower. One of these bedrooms was a twin and another was a three bedded room for female residents. The multi occupancy bedrooms did not maintain resident's dignity due to the layout and the noise within the bedrooms. There was sufficient storage in residents' bedrooms for their clothes and other personal items.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspector found that the provider had put risk management measures in place; however, they needed to be significantly improved. For example, risks associated with fire safety, manual handling practices and the storage of chemicals. Infection control issues were also identified.

The systems for the identification, assessment and management of risk required improvement and measures put in place following adverse incidents to prevent them from recurring required improvement. The centre had policies and procedures relating to health and safety and these were seen in practice.

The inspector found that there was a Health and Safety Statement for each location, however this did not include the environmental issues in each house. It also did not include any risk assessments or any control measures to mitigate risks. While there was a corporate risk register, it did not include all risks associated with the locations. For example, there was no risk assessment for a child who resided in an adult service. The provider described the plans to address this.

At the time of inspection, there was some guidance on the management of an outbreak of infection. While there was a new guidance document for infection control, there were no procedures in place for the cleaning of resident equipment between uses. The inspector found there was an absence of appropriate measures, such as hand sanitizer within the houses. The inspector also found that some of the medical devices such as

the suction equipment was not cleaned regularly and there was dust seen on this equipment in one of the houses.

While there was a new risk management policy, which was revised from the previous inspection and information was provided to staff on the policy, they were not knowledgeable in the management of risk or the completion of risk assessments. They told the inspector they would welcome additional training. Staff said they partially completed the new incident report as they were not knowledgeable on its use.

All risks in the houses were also not identified, such as the staff number and skill mix, for example.

Inspectors observed that residents at risk had access to cleaning chemicals as these were not stored securely.

The managers undertook a review of all incidents and accidents. A report was available on a three monthly basis. However this information was not being used in the houses to improve care for residents. While recommendations were identified they had not been consistently implemented. This information was not being fully analysed to improve the service, minimise the risk of future occurrences and this was a missed opportunity to share any learning for the period.

The inspector found that there were centre specific emergency plans in place. This detailed the procedure for evacuation, contact numbers and the location of mains valves for electricity, water and gas (where applicable). The plan also included the location of alternative accommodation and means of transport should these be needed. However, many of the staff were not aware of the content or how it could be applied in practice.

Fire compliance

Overall fire safety required improvement. The inspector viewed the fire training records and found that staff had received up-to-date mandatory fire safety training and this was confirmed by staff. However, many of the staff spoken to were not knowledgeable of what to do in the event of a fire. The fire procedures on display would not guide practice. While regular fire drills were carried out by staff at suitable intervals as defined by the Regulations, the learning from the drills had not been addressed.

There was evidence that fire equipment was serviced regularly. There was evidence that the fire extinguishers, fire alarms and emergency lighting were serviced. However there was no record of servicing of emergency lighting in one house. The inspector found that all fire exits were unobstructed on the day of inspection. While residents had individual evacuation plans, they were not fully prescriptive to guide staff. The inspector found that staff were not fully familiar with them. The inspector found that they could not be fully implemented in practice in the locations where one staff was on duty at night time.

The inspector noted that there were no fire doors in some of the areas of the houses. The provider was aware of many of the deficits and had an action plan to address the issues.

Judgment:

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspector found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. However, these required significant improvement. The inspector found that residents were not fully protected from abuse. This included the management of residents' finances, peer assault or the action taken when an allegation was reported and was in the process of being investigated. Residents finances were not managed in line with the policy as stated in Outcome 1.

Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. The inspector found that fifty percent of staff had not received training on safeguarding vulnerable adults in the past three years. Further training was planned to include the national policy.

The policy on safeguarding residents from abuse contained guidelines on how any allegations of abuse would be managed. However, this was not detailed to include allegations against a staff member. The provider had appointed a designated adult protection officer. The responsibilities for this person were contained in the policy, and the officer was a resource to staff should they need to discuss any concerns they had.

There was evidence that incidents of all allegations of abuse were appropriately investigated, however the inspector found that appropriate action was not taken to maintain the safety of all residents following an allegation of abuse.

Due to the layout of the premises, staff did not maintain resident's privacy during the delivery of intimate care. All residents had an intimate care plan in place.

There was a policy on the management of behaviours that challenged, which was not been being used fully to guide the care delivered. There was also a new policy that had been approved and was going to be circulated to staff. The new policy was strongly focused on the rights of residents, promoting positive approaches and identifying and

addressing any causes for resident's distress.

Staff had received training on crisis prevention intervention but not specifically in the management of behaviours that were challenging, there were plans in place to provide training on the new policy and procedure. There was evidence that the GP, psychology and psychiatric services were involved in the care as required.

While there were behaviour support plans in place for all residents with behaviour that challenges. These were not reviewed regularly, were not up to date and did not consistently guide care. One residents support plan referred to a coffee shop which was no longer in place.

The inspector reviewed the use of restrictive practices in the centre. Where interventions used were identified as a restriction, residents were reviewed at the rights committee. Staff did not identify all restrictions in use and they were not managed in line with the national policy. Where significant restrictive measures were applied for one of the residents, the inspector was concerned that this placed the resident at risk. When additional information was sought with regards to this resident following the inspection, it was made available. However, it was not of an adequate standard.

The review of the restriction was not consistently documented. Risk assessments for the use of the restriction were not available, therefore the control measures were not documented and the evidence of the options that were tried prior to the use was also not documented. There was a lack of evidence that interventions are regularly reviewed as part of the personal planning process. There was no restraint register for the centre to include all restraint.

The centre had reduced the use of bedrails since the previous inspection. Where residents were using bed rails, there were risk assessments completed, and the staff monitored the resident on an hourly basis. However, one resident's risk assessment identified that the resident was at risk of getting out of the bed with the bedrail in place, but the control measures were not documented. There were no care plans to guide the care of residents who required bedrails and the risk was not being addressed.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found that the staff had maintained records of all accidents and incidents that had occurred in the centre. These were reviewed by the nurse managers. The provider was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date and to the knowledge of the inspector, all relevant incidents had been notified to the Chief Inspector.

Judgment:

Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found that residents' general welfare and development was being facilitated. However, this could be further developed. Residents attended a day service for a period of time during the day. From discussion with staff it appeared that the developmental and welfare needs of the child who resided in the adult services were met. The resident attended the school in the service and accessed the designated centre between two and three nights per week. The resident was not in the centre at the time of the inspection. Staff said that the child enjoyed outings with the other residents and these were facilitated. However, there were no education attainment targets for the resident available for review in the centre.

As outlined in Outcome 1, residents are not always engaged in social activities, internal and external to the centre, due to the number and skill mix of staff. One resident spoke of enjoying the day service and the interaction with the staff there.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspector found that there were appropriate arrangements in place to support residents' health care issues as they arose. The staff in the houses were very familiar with residents' needs and had responded when the need arose. Staff had created links with the health services within Cheeverstown allied health professionals. Evidence based assessments for falls, nutrition and wounds were not in place. While residents had guidance documents in place for epilepsy and dysphagia, there was a lack of care plans in place to guide staff. The epilepsy guidance documents were generic and did not guide the care for all residents.

There was no oxygen available in one house where residents who were prescribed this resided. This was made available when brought to management attention. Where residents received oxygen daily, staff did not consistently check resident's oxygen saturation and there was no care plan to guide this care. One resident's profile was not updated since 2013. A resident with considerable health needs had a profile which would not guide practice. The profile included, "if I am cyanosed (a bluish discoloration of the skin due to poor circulation or inadequate oxygenation of the blood) or my respirations increase, oxygen 4 litres is to be administered". The staff provided inconsistent information to the inspector on when they would respond to this resident's changing needs.

The inspector read the safety plans for residents which were found not to be dated. This was not reflective of the current health needs of the resident.

The inspector also noted that it was the policy on the campus that care staff were not trained in the administration of a medication to manage status epilepticus, therefore residents with epilepsy were restricted from outings if a nurse was not available to accompany a resident.

The inspector reviewed the personal plans and medical folders for seven residents and found that they had access to a general practitioner (GP), including an out of hours service. There was evidence that residents accessed other health professionals such as chiropodists, opticians and physiotherapists.

Overall, there was a lack of evidence that health assessments were completed. Health plans were in place for all residents; however they did not provide valuable information for staff in the care of residents and were not consistently up to date for all residents. They did not reflect the real assessed needs of residents. Many were not updated when the resident's condition deteriorated.

There was no consistent follow through when the need for referrals to other services was identified. While residents were referred to and reviewed at the complex needs committee, there was insufficient evidence of the follow through from this meeting. Staff

were unable to tell the inspector if referrals were made and when appointments were due. There were no care plans in place for residents at risk of cardiac failure and falls.

While two residents had "do not resuscitate" orders on file, there were no care plans to guide the care for these residents. Staff said they had not completed the care plans as they had not received any training in this area. There was access to a clinical nurse specialist in this area and there were plans to train all staff.

Overall residents appeared to enjoy their evening meal when they returned to the centre. In some houses this was an appropriate dining experience where residents decided what they wanted for their evening meal and if any resident did not like what had been prepared, there was a range of alternatives available. Residents were supported to have a snack at any time of the day or night if they preferred.

Residents enjoyed going out for a meal at times. The inspector found that there was an ample supply of fresh and frozen food. Fresh fruit and juice was available during the day which residents could access.

However, the breakfast experience in one of the houses required significant improvement. Residents at risk of choking were not appropriately supervised; they were seen to walk around the house with food in their mouths. Staff were observed to be standing over residents assisting them with a meal. The meal time was hurried and staff said this was to ensure all residents were ready for day services. Assistive devices such as plate guards were not provided to all residents and food was seen to fall from the bowls when residents were independent with eating. The dining areas were small in two of the houses; there was no appropriate dining space for one resident who sat at the counter on a stool in one house to eat a meal to maintain the resident's safety.

Judgment:

Non Compliant - Major

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The inspector was satisfied that each resident was protected by the designated centre's policies and procedures for medication management. The medication policy was revised following the previous inspection. While the inspector acknowledged that action had been taken following the previous inspection. There were a small number of

improvements noted.

The inspector read a sample of completed prescription and administration records and saw that overall they were in line with best practice guidelines. The pharmacist was involved in medication safety and provided support and advice as required. Information pertaining to each resident's medication was available in the residents' files.

Many of the staff nurses had received training in this area and were familiar with the medications in use. As stated, care staff did not administer medication and this was impacting on the access to the community for some residents. Other staff had not completed refresher training. There were no medications that required strict controls in place, but staff outlined the procedure they would follow.

Staff knew about the procedures for reporting medication errors. While a medication audit for the service was completed, staff were not aware of the findings or if any improvements were needed. Medication audits were not completed for each location to identify areas for improvement; therefore there was a missed opportunity for learning. While medication could be stored in a separate fridge in the treatment room, there was no procedure to check the fridge temperatures in line with best practice.

Judgment:

Substantially Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found that the Statement of Purpose did not fully meet the requirements of the regulations. It reflected the centre's aims, ethos and facilities. It did not fully describe the care needs that the centre is designed to meet, as well as how those needs would be met. The room sizes were also not included.

Feedback was provided to the management team on the deficits in this document.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector was concerned that there was no identified person in charge to manage the centre as per the requirements of the Regulations.

The inspector found that there was a lack of clinical governance in the centre which resulted in poor outcomes for residents. Inspectors identified non compliances in the areas of clinical leadership as outlined in Outcome 11, healthcare, risk management and insufficient staffing arrangements as outlined in Outcome 17.

The inspector found that the provider had failed to ensure the arrangements provided sufficient oversight of key areas such as dignity and privacy, fire safety arrangements, risk management and healthcare issues as discussed throughout this report.

The inspector found that while there was a management team in place, there was no person in charge nominated to oversee the management of the designated centre. This concern was brought to the attention of the provider, director of services and senior management during the inspection. They are aware of their requirements under the Act and the Regulations.

There was a senior management team in place. The team included the provider, director of service, assistant director of services, medical director, financial controller, operations and quality manager, human resources manager, employment and training manager. The provider was in the process of planning retirement and a new interim provider met with the inspector during the inspection.

In the designated centre, a team of nurse managers oversaw the day to day running of the centre, and the service was in the process of a management review. The provider assured the inspector that a programme of supervision and mentoring was being planned for nurse managers. However, in the interim, the lines of accountability and responsibility for the provision of the designated centre at service level were not clearly defined or effective. While clinical nurse managers were in post, there was a lack of supervision and support for staff in the designated centre to ensure that the needs of residents are met, incidents are responded to, personal plans implemented and staff supervised. Nurse managers told inspectors that due to the lack of a clinical nurse manager one in one area, they visited the house once per month and were available by

phone, therefore there was no oversight of issues in this house. This included the use of PRN (as required) medication, restrictive practices, resident and staff supervision.

The provider had established weekly clinical nurse manager meetings and overall weekly staff meetings were held in each location. While staff said they have access to the nurse managers by phone, the management style was reactive rather than a planned approach to the management of the service.

The provider had undertaken reviews of the service and an action plan was provided to the inspector. The management team were working through the action plans from the previous inspection. The centre had been externally accredited for quality.

While clinical data was collected, it was not being utilised to improve the service. There were no audits available for review. An annual report of the quality and safety of care and support in the designated centre was not available.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was no nominated person in charge of the designated centre as required by the regulations.

Judgment:

Non Compliant - Major

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found that insufficient resources had been provided at times to meet the needs of residents. There were insufficient staff on duty at times and the layout of the houses did not meet the residents' needs. Please see outcome 6 and 17.

The inspector found that the provider had ensured that sufficient personal equipment had been provided. However, there was an insufficient number of staff on night duty to provide personal care and use equipment as prescribed by the physiotherapist. The inspector found that in one house, which was located in the community, approximately 15 minutes drive from the campus, the staff called the night staff in the campus to support with personal care for one resident at night. Staff said that the resident remained in wet incontinence wear for a long period of time until support arrived, or they carried out this intervention alone on many occasions as the night staff were too busy. This procedure would place the staff and resident at risk.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspector found that overall there was a very committed and caring staff. Staff knew the residents well. There were significant deficits identified in the number and skill mix of staff and this placed residents at risk.

There were areas for improvement noted in the number of staff on duty on a consistent basis to meet resident's needs. The provider told the inspector that he was actively recruiting new staff to address the deficits. There was still a reliance on agency staff.

The inspector found that the provider had established a relief panel since the previous inspection, with an aim of providing a consistent service to residents. However the

folders which they were to refer to regarding the residents needs did not set out the residents needs in one of the houses.

The inspector found that the staff number and skill mix was not consistent to meet the changing needs of residents with health care issues in the three locations. The inspector found that one of the staff was frequently moved from one of the houses to others when there was a staffing deficit in another area. This may have negative outcome for the residents in this house who had complex healthcare needs. Nurse managers confirmed that the staffing number was based on historical data and not on the assessed needs of residents. The inspector found that if a resident was ill or refused a day service, they would have to move to another location during the day and were care for by staff who were not fully familiar with the resident. In one location residents outings were cancelled if there were not enough staff on duty. There was no process to capture this information, therefore management were not aware of the scale of the problem. The inspector found that many of the residents who required two people for moving and handling went to bed by 19.30hrs in order to ensure there was sufficient staff to support them. Some of the staff nurses leave their own houses day and night to administer medication in other houses.

Staff files were reviewed and contained all of the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. This was identified at the previous inspection and was addressed.

While performance reviews were in place, as previously stated the supervision of staff required improvement. The follow through of the training needs identified were not always in place.

Training records were reviewed by the inspector. There were some gaps noted in the mandatory training (fire response training, moving and handling of residents and prevention and awareness of abuse). However the provider was aware of these gaps and inspectors reviewed a schedule of training which responded appropriately and in a timely fashion.

While staff had access to training, they were not kept up to date on residents' specific clinical issues. Staff had not received training to care for residents with specific intellectual, sensory and physical needs such as autism, aspiration, restrictive practices, mental health issues, risk management and infection control.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to

residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found that records were accurate and up to date, and maintained securely but easily retrievable.

The inspector was satisfied that the records listed in schedules 2, 3 and 4 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. However there were areas for improvement. The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. This included the risk management, infection control policy, end of life policy and the finance policy. These policies had been revised since the previous inspection and were in the process of being rolled out to guide practice. The inspector found that residents' records were not maintained in line with best practice. The date and time was omitted from many of the residents' records.

An up to date insurance policy was in place for the centre which included cover for residents' personal property and accident and injury to residents in compliance with all the requirements of the regulations.

Judgment:

Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Linda Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004924
Date of Inspection:	21 and 22 April 2015
Date of response:	18 June 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents dignity was not well maintained as outlined in outcome one.

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents did not have a bank account in their own name,

Action Required:

Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

Please state the actions you have taken or are planning to take:

The service implements fully the guidelines of patient private property accounts as outlined by the HSE.

The service has opened individual bank accounts for people in their own name.

The system to implement the roll out of these bank accounts to residents will be in place by mid July 2015

The service will cease to hold money on behalf of residents unless specifically requested to do so by 30th September 2015

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Due to the routine practice in the centre, residents were not supported to make choices in their daily life. Activities are dictated by the routine and resources of the centre and not by the wishes of the residents

Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:

“The action plan submitted by the provider does not satisfactorily address this failing identified in this report”.

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The complaints procedure was not on display.

Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:

The accessible version of the Complaints Procedures will be on display in each residence; this will include a picture of the Complaints Officer, contact details and details of the Appeals Process. The full Complaints Policy is also available in each house but not on public display

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Information on how to contact an external advocate was on display, however staff who supported residents were not familiar with this person or how to access the service.

Action Required:

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

Please state the actions you have taken or are planning to take:

Information pertaining to advocacy services will be made available in each residence. Information on access to external advocacy services will also be included.

Proposed Timescale: 30/06/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The communication passports were not consistently updated for all residents to include their current needs.

Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Internet access was not provided to residents to enhance their communication. there were no assistive devices available to support residents communication needs.

Action Required:

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Please state the actions you have taken or are planning to take:

The designated centre will be assessed for WIFI internet access as part of the implementation of the organisations new Management Information System. A pilot project has commenced on the use of assistive technology.

Proposed Timescale: 31/10/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The agreement for each resident was not in line with the regulations.

Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be

charged.

Please state the actions you have taken or are planning to take:

The service will ensure that the agreement for each resident (Memorandum of Understanding) is in line with the regulations.

In this regard the Memorandum of Understanding will state the amount of each resident's long stay charge following their assessment

Proposed Timescale: 30/06/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Personal plans did not reflect the assessed needs of residents. There was no link between the personal plans and the support provided to residents.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The assessment did not have multidisciplinary input and did not assess the effectiveness of the plan.

Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The garden areas were not properly maintained.

Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:

The broken furniture in the garden of house three has been removed

The company is now dependent on the goodwill of a volunteer gardening support group which will maintain the gardens in this Designated Centre under the directions of the Operations Manager.

Furniture removed: 31st May 2015

Maintenance of gardens: Ongoing

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The premises did not meet the requirements of the Regulations or the needs of residents.

Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The risk management policy was not being implemented in practice in relation to the identification, assessment and management of risk.

Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There were a number of deficits in fire safety in the designated centre.

Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Many of the staff spoken to were not knowledgeable of what to do in the event of a fire. The learning from the fire drills had not been addressed.

Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Restrictive practices were not managed in line with evidenced based practice or the national policy.

Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff had not received training in the management of behaviours that were challenging.

Action Required:

Under Regulation 07 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:

Training on the services Policy "Promoting positive approaches, meeting needs and reducing distress" will be rolled out until all staff are trained, commencing 31st July 2015

The service also delivers "Management of Actual and Potential Aggression" (MAPA) training which has replaced the Crisis Prevention Institute (CPI) training which commenced in April 2015. This is provided by four certified in-service trainers.

The service also provides specific Autism Awareness Training, Communication Passport training and specific training on Mental Health in Intellectual Disability.

These training programmes address the management of behaviours that challenge in this service

Commenced April 2015 and ongoing

Proposed Timescale: 25/04/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents were not protected from all forms of abuse.

Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Due to the layout of the premises, staff did not maintain resident's privacy during the delivery of intimate care.

Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Appropriate action was not taken to maintain the safety of all residents following an allegation of abuse

Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There were no education attainment targets for the child available for review in the centre.

Action Required:

Under Regulation 13 (4) (c) you are required to: Ensure that when children enter residential services their assessment includes appropriate education attainment targets.

Please state the actions you have taken or are planning to take:

The individual educational plan (IEP) for the child is now on their file in the designated centre. Completed

Proposed Timescale:

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Evidenced based assessments for falls, nutrition and wounds were not in place. Health plans did not provide valuable information for staff in the care of residents and were not consistently up to date for all residents. They did not reflect the real assessed needs of residents. There were no care plans to guide care.

Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no consistent follow through when the need for referrals to other services was identified.

Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Improvements were required in the dining experience as outlined in outcome 11.

Action Required:

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Aspects of medication practices were not in line with the centres policy or best practice.

Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:

Centre policy to be reinforced to all staff.

Refresher training will be provided to all staff in medication practices. The service will reinforce best practice in prescribing, storing and disposal and administration of medication.

Proposed Timescale: 31/07/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The inspector found that the statement of Purpose did not fully meet the requirements of the regulations.

Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale: 31/10/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no identified person in charge to manage the centre as per the requirements of the Regulations.

Action Required:

Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

Please state the actions you have taken or are planning to take:

The Person In Charge has now been appointed and the service is processing the necessary paperwork for submission to the registration department in HIQA

“AT THE TIME OF REVIEW THE DOCUMENTATION WAS NOT RECEIVED BY THE AUTHORITY”

Proposed Timescale: 12/06/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

An annual report of the quality and safety of care and support in the designated centre was not available.

Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure 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.

Please state the actions you have taken or are planning to take:

The service will provide an annual report of the Quality and Safety of Care and support.

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was a lack of clinical governance in the centre which resulted in poor outcomes for residents.

Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

“The action plan submitted by the provider does not satisfactorily address this failing identified in this report”.

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The lines of accountability and responsibility for the provision of the designated centre at service level were not clearly defined or effective.

Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The inspector found that there were insufficient resources had been provided at times to meet the needs of residents.

Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There were significant deficits identified in the number and skill mix of staff on duty to meet residents needs.

Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff did not have access to training to meet residents needs.

Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:

"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The policies did not guide practice. This included the risk management, protection, infection control policy, end of life policy and the finance policy.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

Policy roll-out and associated training will continue into 2015 in order to guide practice

