

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Cheeverstown House Limited
<b>Centre ID:</b>	OSV-0004130
<b>Centre county:</b>	Dublin 6w
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Cheeverstown House Limited
<b>Provider Nominee:</b>	Tom Nolan
<b>Lead inspector:</b>	Sheila McKeivitt
<b>Support inspector(s):</b>	Conan O' Hara
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	12
<b>Number of vacancies on the date of inspection:</b>	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 monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 03 November 2015 08:00 To: 03 November 2015 21:00

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 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 11. Healthcare Needs
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

The inspection took place to assess compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards of Residential Services for Children and Adults with Disabilities. Inspectors also followed up on areas of non compliance identified at the previous inspection, which had taken place to inform a registration decision on 14 and 15 April 2015. At that inspection a significant number of non compliances were identified.

As part of this inspection, inspectors met with residents and staff members, observed practices and reviewed documentation such as personal plans, accident logs, policies and procedures. At the time of the inspection 12 residents resided in the designated centre which comprised of three houses based in a suburban residential part of Dublin.

At this inspection, inspectors found good progress had been made in addressing the non compliances from the previous inspection. Since the last inspection, a person in charge had been nominated to oversee the service. The person in charge previously attended a fit person meeting in the Authority's offices and had been met at previous inspections of the centre. He was very familiar with the residents' health and social care needs, demonstrated good knowledge of the requirements of the Regulations and he was familiar with his requirements therein.

There were improved practices to meet the residents' identified healthcare needs. The inspectors found improved practices in the management of complaints and the complaints procedure in an accessible format was displayed in each of the three houses. There were improved practices in medication management.

Staff were observed to treat the residents in a patient, respectful and friendly manner, and were knowledgeable of their social and healthcare needs. There was good access to medical, pharmaceutical and a range of allied health professionals, and where requested by residents, this was facilitated. There were adequate staff skill mix and numbers in place, however their deployment, training and formal supervision required review.

The premises was maintained in good repair, nicely decorated and homely for the residents who lived in them. However, improvements were identified, as the management of risk and fire safety required improvement. A plan to replace a bedroom window with a glass fire door had been progressed but not completed. This merited a judgment of major non compliance. The documentation, development and review of residents personal plans required review. Due to the layout and size of residents' files, information was not easily accessible.

Inspectors found improvements were required to ensure adequate governance of the centre. The new person in charge was also responsible for another designated centre and sometimes was covering two additional community designated centres. Inspectors were not satisfied with the arrangements in place for deputising in his absence.

The monitoring of the quality of care provided in the centre required improvement. The unannounced inspections were not detailed enough to ensure the quality of care and service would improve and there was no annual review of the safety and quality of care in the centre carried out to date.

A number of actions from the last inspection appear again on this report as they had not been progressed and completed. These and all other matters are outlined in the report and action plans at the end of the report.

**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:**

Inspectors found the provider and staff had systems in place to ensure residents were involved and participated in decisions about their care and the organisation of the centre. However, some improvements were required in relation to the complaints policy and maintaining residents' privacy and dignity.

The centre was managed in a way that maximised residents capacity to exercise personal independence and choice in their daily lives. There were regular house meetings taking place in each house and it was clear that residents planned their day, routine and activities. However, minutes of these meetings were kept in a book together with minutes of staff and management meetings. This did not ensure the privacy of all parties. Inspectors noted that there was no evidence that issues brought up by residents were addressed as minutes of previous meetings were not reviewed at meetings. Private information in relation to a number of residents was displayed in other residents' bedrooms and in communal areas. Also, staff notices and information pertaining to them was displayed in the residents' communal rooms although there was a staff office in each of the houses. One resident told the inspector that they had told staff he did not like the sight of all the notices in his kitchen because it looked like an office. However, it had not been changed to date.

Residents told inspectors they had met with their internal advocacy representatives and showed the inspector his photo and dates of upcoming meetings on display in each house. Contact details of the National Advocacy Committee were also on display in the houses together with lots of information about their rights. Inspectors were told that all

residents were registered to vote from their home and those who choice to exercised that right. All three houses were located close to a church which some residents attended independently; others were facilitated by staff to attend if they so wished.

Staff respected residents' privacy and dignity. However, there were no privacy locks on a number of bedroom doors in the houses. Therefore, residents could not be independently maintain their privacy.

There was a policy on the management of complaints and a copy was on display in each of the houses however, the policy did not reflect the practice. The inspector saw that complaints were dealt with promptly at local level, records reviewed of closed complaints were clear and concise. They included details of the investigation, the outcome and level of satisfaction of the complainant. The policy did not reflect the person nominated to deal with complaints in each house, the appeals person or the person responsible for reviewing complaints.

There were policies and procedures on the management of residents' finances and systems were in place to support residents to manage their day to day monies. A sample checked by the inspector were found to be correct with receipts in place for all expenditures. Staff had systems in place to check each resident's balance daily. There were audits carried out by the management team and finance departments.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

Inspectors found there were systems in place to assess and meet residents' communication needs.

There was a policy in place that set out the importance of identifying and meeting residents' communication needs and a system for identifying the level of support residents required. Residents had their communication needs assessed on admission. The assessments were detailed and reflected the residents' communication needs. Residents identified with communication needs had communication passports in place that gave an overview of their communication style, and other key information people may need to know about them.

Throughout the inspection, inspectors saw that staff were communicating well with residents and understood their individual ways of speaking and communicating. Residents appeared confident in making themselves understood.

Residents had access to telephones, televisions and radio. Some also had access to mobile phones as was their choice. Residents were seen to be accessing local shops to buy papers and magazines of their choice.

Many of the policies and guidance documents were provided in an easy read format that would support some residents to understand them.

**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):**

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

**Findings:**

The admission policy and contract of care had both been reviewed since the last inspection however, both required further review.

The admission policy had been reviewed in March 2015. On reading inspectors found it did not reflect the inclusive admission and transfer process practiced in the centre. For example, it did not state that residents and their next of kin were invited to visit the house, meet the residents, stay overnight and were involved in the re-decoration of their personal space prior to their admission.

There was a contract of care in place; it was called the memorandum of service provision. It included written and pictorial information regarding the services and facilities provided. However, it did not detail what utilities or access to which members of the allied health care team were included in the monthly fee. In addition, it did not outline what additional charges could be charged to the resident. The document was signed and dated by the resident or their respective next of kin however, it was not signed by the provider, person in charge or a representative from the organisation.

**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:**

Inspectors found each resident's wellbeing was maintained by a good standard of care and support. However, improvements were identified in the development and review of personal plans for residents. There were good practices in the provision of and access to opportunities to participate in meaningful activities appropriate to their interests.

Staff were familiar with residents' social care needs. Residents living in the houses required staff support and assistance as all had either a mild to moderate intellectual disability. Inspectors reviewed the personal plans of two residents. However, the files were contained within five large folders, therefore it was difficult to identify the most up-to-date information on each resident. Furthermore, information was not up-to-date in all folders, with historical information, such as letters, alongside current information. This is discussed further under Outcome 18. Inspectors were informed that work was taking place on removing excess information from residents' files.

The personal plans for residents' social care needs were called "personal outcome measures" (POMs). Each resident had a POM assessment which was completed by a key worker in consultation with the resident. Inspectors spoke to two residents who were aware of their goals and one resident showed a poster in her bedroom that summarised each goal. Their files were available to each resident however, they were not in an accessible format for residents to understand. Where residents refused to be involved in an assessment this was acknowledged and clearly recorded.

The personal plans reviewed were holistic and focused on a varied aspect of residents' lives, such as purchasing a tablet/ipad, making new friends, visiting parents grave and visiting friends. There were monthly evaluations of each resident's goals, however, these were incomplete, often limited to discussing one goal. In addition, there was no evidence of multi-disciplinary input, or resident involvement in the reviews, or whether

each resident's goals were being met. These issues were identified at the last inspection and not completed. At the last inspection in April 2015 new personal plan documentation was seen by inspectors which was expected but had not yet been rolled out across all houses.

The overall documentation of care plans for residents' identified healthcare needs required improvement. Inspectors found the residents had a range of identified needs however, care plans were not developed for example, bedrails, incontinence, epilepsy and hoist usage. In addition, there was no evidence of regular assessment of residents healthcare needs to ascertain any changes in their healthcare needs. This is discussed further in Outcome 11 (Healthcare needs).

The person in charge ensured each resident had interesting things to do during the day in line with their assessed needs. Inspectors found some of the residents attended a number of activities and day services both internal and external to the service. Some had personal assistants who provided 1:1 care a number of days per week. Residents told inspectors they enjoyed going hill walking, attending the arch club and going to the local public house. The residents led independent lives and also came together as friends and did group activities such as drives to Howth.

**Judgment:**

Non Compliant - Moderate

**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:**

Inspectors followed up on the non compliances identified on the last inspection only under this outcome.

The centre comprised of three houses, all of which were visited by inspectors who found them to be well laid out and meeting the individual needs of the residents. The houses were clean, warm, well maintained and homely. Inspectors saw the physical design and layout met the requirements of the Regulations, with an area for improvement identified during the last inspection remaining unaddressed. As identified in the last inspection report, in one of the houses the layout of a ground floor bedroom and en-suite shower

room did not fully meet the individual needs of the resident. The resident informed the inspector that their bedroom remained too small. The ensuite shower room was not large enough for the resident to transfer from their wheelchair. While there was appropriate assistive equipment provided the resident could only be transferred into a shower chair in their bedroom due to lack of space in the ensuite. Inspectors saw that screening had been put in place in the two bedded room in the house.

The centre was maintained to a high standard cleanliness and hygiene. Rooms were decorated in accordance with the wishes of the resident and contained personal items such as a television, family photographs, posters and various other belongings.

Inspectors were informed that staff and the residents both carry out the cleaning procedures. There was suitable cleaning equipment provided.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

Inspectors found there were systems in place to promote and protect the health and safety of residents, staff and visitors to the designated centre. However, the implementation of the risk management policy and the systems in place to contain fire required improvement.

An up-to-date risk management policy had not been provided to inspectors during the inspection. At the end of the inspection a new version shown to inspectors confirmed it met the requirements of the Regulations. However, the policy was not fully implemented in practices. A safety statement was seen and it included the environmental issues in each house. However, risk assessments on the environment of each house had not yet been carried out or any control measures put in place to mitigate any risks. A draft risk register was shown to inspectors however, it did not identify risks such as the unsafe storage of mops in the centre. Inspectors were informed the plan was to roll out the risk register in the three houses but although an action at the last inspection this issue was not addressed.

There were policies and procedures relating to health and safety and these were seen in practice. Since the last inspection safety audits were completed. The inspection forms read by inspectors confirmed these checks included a range of health and safety issues

including maintenance and fire safety. Where issues were identified such as maintenance risks, these would be brought to the attention of the properties manager.

Inspectors found there was no infection control policy in place. There were generic guidance documents from the Health Service Executive to support staff. While there were no current infections in the houses, there was no centre specific guidance to inform staff. This was an action at the previous inspection and was not addressed. This is discussed in Outcome 18.

There was an organisation wide emergency plan and staff were familiar with it. However, alternative accommodation in the event of an unplanned evacuation was not identified. This was discussed at feedback. Inspectors also discussed the service considering having a bag in each unit that containing essential supplies in the event of an evacuation from the centre.

There were procedures in place on the management and prevention of fire. Fire procedures were prominently displayed in each unit. Inspector viewed the fire safety training records and found that staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire and regular fire drills and unannounced fire evacuations were carried out by staff at suitable intervals, including night time. Residents informed the inspector they had taken part in the fire drills. Records of these fire drills included learning outcomes. Staff had identified how a resident in one house could not be safely evacuated from their bedroom. This was identified on the last inspection report, the plan then was to replace the resident's bedroom window with a glass fire door; however, although planning permission for this door had been obtained it had not been put in place.

There was evidence that fire equipment was serviced regularly, with the fire extinguishers, fire alarms and emergency lighting serviced as per the standards. Inspectors found all fire exits were unobstructed on the day of inspection and documented checks were completed by staff on a daily basis. However, all fire escapes were not clearly identifiable in each of the three houses. Also, there was no plan beside the fire alarm to show which zone was linked to which room in the house.

Since the last inspection fire doors were being installed throughout the centre however, a number of fire doors had yet to be installed some houses. A list of the areas where deficits were identified was shown to inspectors which confirmed where fire doors had been completed and those yet to be fitted. Inspectors were assured that these works were being prioritised. Following the inspection senior management confirmed that works will be completed by February 2016.

**Judgment:**

Non Compliant - Major

**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):**

**Findings:**

The inspector found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. Overall, this outcome was compliant.

There was a policy on safeguarding residents from abuse which contained guidelines on how any allegations of abuse would be managed. 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.

Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. Records were read of training provided to staff on safeguarding vulnerable adults.

There was evidence that incidents of allegations of abuse were appropriately investigated and managed in accordance with the centre's policy. Inspectors met the manager deputising for the person in charge, and she was knowledgeable of the procedures in place to report allegations of abuse. She was supported by the designated liaison person who organised the investigations to be carried out.

Throughout the inspection, inspectors noted that staff interacted with residents in a kind, caring, respectful and patient manner. Staff maintained residents' privacy during the delivery of intimate care. All residents had an intimate care plan in place, which guided care. Overall residents confirmed that they felt safe and secure in their home, the house doors were locked at night and the alarm set.

There was a policy on the management of behaviours that challenged, which was being used to guide the care delivered. Staff had training in the management of challenging behaviours and residents who displayed behaviours that challenged had behaviour support plans in place. There was evidence that the GP, psychology and psychiatric services were involved in the care as required. The support plans reviewed guided staff practice on how to manage the behaviours.

There was very little use of restrictive practices in use in the centre. These were limited to bedrails and lap belts. Inspectors read risk assessments completed, and there were checks carried out by the staff when restraints were in place. To ensure residents' rights were respected, night checks took place once a night, and therefore residents were not

disturbed over night. Residents who required this would have been reviewed at the rights committee.

**Judgment:**

Compliant

**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):**

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

**Findings:**

The Authority had been notified of all notifiable events which had occurred in the centre since the last inspection.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

There was evidence that the healthcare needs of residents were being met. However, improvements were identified in relation to reviewing residents' healthcare needs and the development of healthcare plans.

An annual assessment of residents healthcare needs called a "health profile screening tool" was completed by staff. The was a general overview of each resident's needs outlined in the document. In addition, a health action plan was also seen by inspectors, however this document was often incomplete. Residents did not have a care plan in place to reflect each need identified on assessment. For example, one resident who was

assessed as being incontinent did not have a detailed care plan in place to reflect the care required to meet their incontinence needs. Inspectors read information/guidance documents on file in relation for example, the management of epilepsy or the use of a hoist however these contained insufficient detail for staff to follow to ensure resident's healthcare needs were met. The action in relation to this is detailed under Outcome 5 (Social Care Needs).

The inspector reviewed records that confirmed residents had access to the services of a medical practitioner of their choice. Records and interviews demonstrated that there was regular access to the GP and staff were observant and responsive to any changes in the healthcare status of the residents.

There was access to psychiatric services and psychology services within the organisation. The psychology team provided further service for behavioural management and support for residents as mentioned under outcome 8. Inspectors saw information that residents had access allied services such as dietician, occupational therapy, physiotherapy, speech and language therapy and chiropody. However, letters of referral and visits were not kept in order of date visited with historical information stored alongside up-to-date information. It was also difficult to identify residents' most up-to-date appointments and next appointments as this information was not clearly recorded and stored on their files. See outcome 18.

Inspectors were informed by residents that they had access to adequate quantities and a good variety of nutritious food to meet their dietary needs and preferences. Their preferred foods were recorded in their individual assessment and some residents confirmed they were involved in shopping, preparation, cooking and serving and selection of food for themselves and their house mates. Residents in some houses had their meals prepared for them and brought to the house from their day care facility. Inspectors found that where residents had specialised dietary requirements these were being met. For example, one resident had diabetes, and staff were familiar with resident's needs. Another resident who was on a modified textured diet had clear guidelines from the speech and language therapist.

**Judgment:**

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):**

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

**Findings:**

The statement of purpose had been updated since the last inspection. However, it was not fully compliant as it did not include some of the required information outlined in schedule 1 and did not accurately reflect the centre.

The inspector reviewed the updated Statement of Purpose dated September 2015. Information included was not clear and concise. For example, under advocacy it was not clearly outlined what the advocacy services and contact details available to residents were. Under specific care and support needs intended to be met, it read "all of these houses are staffed by and are therefore not able to respond to residents who require active night supports". This section was unclear as some residents living in the houses have conditions that may require active support at night. Other items were excluded, for example, there were no room measurements written in and they could not be identified from the room plans included. The organisation structure or whole time equivalent of staff were not reflected. Also under age-range and sex it was not made clear that only 18 year olds and older only were accepted.

A copy of the current statement of purpose was accessible to residents within each house in the centre.

**Judgment:**

Substantially Compliant

**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):**

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

**Findings:**

Inspectors were satisfied that the person in charge was suitably qualified, experienced and full time in his role. This was an improvement from the last inspection, and fully addressed. He was present at the inspection on the second day, and fully participated in the inspection process and demonstrated appropriate knowledge of the Regulations. A fit person interview had been held with the person in charge in the Authority offices in July 2015.

The residents were very familiar with the person in charge who was observed to spend time talking and interacting with them. The person in charge was responsible for two designated centres. In addition, he also carried out management duties in two other designated centres. There were two assistant managers who supported and deputised for the person in charge, but the rostering arrangements meant these persons were usually not scheduled to work on the same days and therefore all duties had to be carried out by the person in charge. Inspectors found this arrangement was not adequate and it was evident this was having a negative impact on the quality of the service as evidenced in the report and outlined below.

The centre was operated by the Cheeverstown House Limited. There was a clear senior management team in place which included the provider nominee (manager of quality and strategic planning) who was new to the role since 2 November 2015, a director of services, assistant director of services and other heads of department within the organisation. However, within this management structure the lines of authority, accountability and responsibility for the provision of the service at centre level were not clear. Inspectors were not satisfied that the governance and management arrangements provided an adequate level of supervision of care and practice in order for the centre to be in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. This was supported by the findings of this inspection, with examples as follows:

- residents' files and information would not guide staff practice,
- healthcare plans were not developed for residents' identified needs,
- fire safety deficits identified in the centre were not fully addressed,
- the management of risk was not effective,
- there was inadequate evidence of a systematic process for the ongoing review of quality and safety in the centre, as evidenced in outcome 8.
- the centre was not adequately resourced at certain times of the day,
- staff were not formally supervised,
- staff meetings were not happening frequently or documented,
- person in charge not fully supported in his role.

Inspectors read reports of unannounced visits to one house in the centre. There were findings outlined however, there was no action plan or persons delegated to address the issues identified

There was no overall annual review of the safety and quality of the service as required by Regulations. This was action at the previous inspection and not addressed.

**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:**

Inspectors found there were sufficient resources available to meet the needs of residents however, they were not deployed effectively throughout the centre to ensure there was autonomy in each of the three houses.

Inspectors found resources were not effectively deployed to support resident's individual needs. For example, staff worked a shift pattern that ended at 9am in the morning - effectively when residents then left their homes to attend a day service or work. This meant there was no staff available in the homes if residents wished to remain there if they felt unwell or decided they liked a day at home. This was not in keeping with meeting the resident's assessed needs.

**Judgment:**

Non Compliant - Moderate

**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:**

Inspectors found there was experienced staff to meet the assessed needs of the residents at the time of the inspection. However, improvements were required in relation to staffing levels at times of the day in parts of the centre and supervision of staff.

The staff in the centre were appropriately qualified and there was a suitable skill mix to meet the needs of the residents. Staff were knowledgeable of the residents and their needs, were friendly and patient with the residents and had a good relationship with

them and their families. Inspectors found staff was knowledgeable of policies and procedure, which were available to them in the centre.

As reported in outcome 16, in two of the houses, staff were not rostered between 9am and 4pm when residents were at their day centres. While the person in charge said there was cover available, it could only be provided with sufficient advance notice, and as such the houses did not have the staffing levels for residents who wished to stay at home or were unable to attend day service, particularly residents of advanced age.

There was a planned roster read by inspectors. However, the rosters did not include the full names of persons, their grade and if they were agency or relief staff. See outcome 18. This was discussed with the person in charge during the inspection.

There was no formal arrangements for one-on-one supervision meetings in the centre. This had been an action and the previous inspection was not addressed.

Inspectors were satisfied a recruitment policy was in place and it was being followed in practice. Personnel files were not reviewed at this inspection however inspectors had reviewed a number of personnel files at previous inspections. These files will be monitored through future inspections. A service level agreement reviewed at the previous inspection gave assurance of the qualification and vetting of agency staff.

Inspectors read training records for the centre. The person in charge ensured all staff in the centre were provided with access to mandatory training including fire safety and protection of vulnerable adults. However, records read showed some staff had not completed training in the prevention of abuse in over two years, and others had not completed fire safety training in over one year.

The staff had also completed training in movement and handling of residents. However a number of gaps were identified. Other training attended by staff included areas such as manual handling, first aid, CPR, and the safe administration of medication. In addition, some staff had completed training in eating and drinking training, epilepsy awareness and the administration of buccal midazolam.

A number of relief staff worked in the centre and there was evidence of regular training provided to these staff in all mandatory areas.

**Judgment:**

Non Compliant - Moderate

**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*

**Theme:**

Use of Information

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

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

**Findings:**

Inspectors found that there were systems in place to maintain complete and accurate records and the required policies were in place.

Inspectors found there were records required to be maintained for each resident. The maintenance of residents' files and accessibility of their information required improvement. Since the last inspection, the provider and person in charge had reviewed all files. A new system of documentation was being piloted within the organisation, of which drafts were seen by inspectors, and this work is acknowledged by inspectors. However, further improvement was still required. There were between four and five folders for each resident that contained their personal information. Each folder contained large volumes of information and as a result it was difficult to ascertain residents' most pertinent support and care needs. See Outcome 5.

Inspectors had reviewed policies and procedures at the previous inspection. The provider had ensured the designated centre all of the written operational policies as required by Schedule 5 of the Regulations. While all policies required by Regulations were in place improvements were identified. For example: there was no infection control policy, the finance policy did not reflect practice.

**Judgment:**

Non Compliant - Moderate

**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:***

Sheila McKeivitt  
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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Cheeverstown House Limited
<b>Centre ID:</b>	OSV-0004130
<b>Date of Inspection:</b>	03 November 2015
<b>Date of response:</b>	15 December 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:**

There were no privacy locks on residents' bedroom doors.

#### 1. 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

<sup>1</sup> 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:**

- Privacy issues will be reviewed in each house. Each resident will be consulted through the Personal Outcome Measures "Right to privacy" to assess this and provide a lock or support regarding privacy issues.
- This review will be completed with each resident by the end of January.

**Proposed Timescale:** 30/01/2016

**Theme:** Individualised Supports and Care

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

Personal information about residents was displayed in communal areas of the houses.

**2. 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 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:**

- PIC and named house staff will review all information in each of the homes in this Designated Centre to ensure that any personal information is stored in personal files. The PIC, Provider Visit and Visitation template will capture this also.
- Folders for EDS guidelines are kept in each kitchen with related information to guide practice.
- A meeting will be held with residents to discuss where personal information should be displayed.

**Proposed Timescale:** 31/01/2016

**Theme:** Individualised Supports and Care

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

There is no evidence that residents' requests/views sought at meetings are acted upon.

**3. Action Required:**

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

- The minutes of staff and resident meetings will be held in separate books
- The agenda for the Resident meetings will include a review of the previous actions / issues to be addressed will start with immediate effect when the separate books are in place.

**Proposed Timescale:** 01/01/2016

**Theme:** Individualised Supports and Care

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

The complaints policy did not clearly identify the person nominated to deal with complaints at local level, the appeals person and the person nominated to oversee complaints.

**4. Action Required:**

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

- The accessible complaint procedure will be updated to ensure it clearly identifies the nominated person at local level, who is the appeals person and the person who will oversee complaints.
- Target for the procedure update is 14th Dec for DC 7 & 8. Implementation plan for the communication and implementation will commence with target completion date Jan 30th 2016

**Proposed Timescale:** 31/01/2016

**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 document was not agreed/signed by a representative from the organisation.

**5. Action Required:**

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

Memorandums to be signed by the PIC, Residents or Representative

**Proposed Timescale:** 28/02/2016

**Theme:** Effective Services

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

The document did not clearly outline the services and facilities included in the monthly fee.

**6. 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 memorandum of service provision will be individualised for the residents specific and unique requirements:

- What utilities are to be paid
- Which allied healthcare team / professional are included
- Potential additional charges which could be charged
- This will be led out by the Financial Controller, Management and PIC

**Proposed Timescale:** 28/02/2016

**Theme:** Effective Services

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

The document did not clearly outline the additional fees which could be charged to the resident.

**7. 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 revised memorandum will include any additional fees which the resident may incur as part of their contract of care.

**Proposed Timescale:** 28/02/2016

**Theme:** Effective Services

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

The admission policy did not reflect admission practices.

**8. Action Required:**

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

Policy to be amended and updated to include the following:

- Resident and Next of kin involvement in initial house visit, redecoration of room and option to stay overnight.
- Consultation to take place with individuals living in the house.
- Transition plans should reflect policy changes above.

**Proposed Timescale:** 28/02/2016

**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:**

The reviews of residents' personal plans did not include an evaluation of their effectiveness.

**9. 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:**

- Standard Operating Procedure on Compiling, Maintaining and reviewing a personal plan will be implemented.
- This identifies a time frame of 6 monthly reviews including actions completed and auditing of personal plan annually by Plan Coordinators / Managers / PIC
- Data on the effectiveness and whether goals are achieved under individual plans are inputted on the Quality database and accessible by all managers.

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

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

There was no multidisciplinary input in the review of residents' personal plans.

**10. Action Required:**

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

- Revised Personal Plans will be implemented which reflect plans of care including risk assessment forms and MDT input.
- These will be implemented by the PIC and keyworker with support from the Quality Department.
- A pilot has already commenced in 3 designated centres.

**Proposed Timescale:** 30/03/2016**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Residents' personal plans were not available in an accessible format to the residents and, where appropriate, their representatives.

**11. Action Required:**

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

The My Life Plan which is a summary of the identified goals will be in an accessible format for each resident.

- The revised Personal Plan being implemented will include the following:
  - Things you must know about me
  - Things that are important to me
  - Things I like dislike and other information
- A communication matrix will be completed with each resident. This will inform the level on which information may be adapted and explained. This will be done by the keyworker and collaboration.

**Proposed Timescale:** 30/03/2016**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Residents did not have care plans in place to reflect their health care needs.

**12. Action Required:**

Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

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

- Healthcare Plans have been included in the revised personal plans which are being piloted in 3 designated centres including this designated centre. This pilot commenced the 1st of October.
- The SIT (service improvement team) and Quality dept. and relevant healthcare professional have informed the development of Personal care plans which includes a comprehensive assessment of an individual's care needs and from this the development of a plan of care which will guide practice.
- The development of these care plans will be facilitated and signed off by identified healthcare professionals.
- Implementation of Revised Personal Care plans will be in place within this designated centre with the support of the identified planned coordinators.
- The PIC and the planned coordinator for this designated centre will complete the implementation of the healthcare plans commencing the 14th of December.
- These plans will be reviewed at a minimum of 3 months and rewritten every 12 months by the identified house lead.

**Proposed Timescale:** 30/03/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

A single bedroom as described in the report was not of suitable size to meet the residents needs.

The en-suite shower room described in the report was not of suitable size to meet the residents needs.

**13. 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:**

- Meetings have been held weekly since the 4th of November to look at possible solutions. Meetings involve the team around the resident, the resident and her family to discuss accommodation options.
- A review of the existing accommodation available to Cheeverstown has taken place (community group homes). One house was identified with a bigger bedroom which would allow greater ease of access by staff to assist this resident. The resident would have access to a downstairs bathroom but the dimensions are small. This has been

considered but it does not prove to be a better option for the person because of the bathroom dimensions. Extensions to existing community houses were considered but are not a suitable option.

- An application for social housing was submitted to South Dublin County council for this resident in November 2015.
- On Friday the 4th of December the provider and O.T. met with SDCC regarding an accessible bungalow which is being built.
- The housing design will meet the needs of the resident involved. The plans were reviewed by O.T., Housing officer and Architect South Dublin County Council. The O.T. will be involved in the design of the bungalow to meet the resident's needs.
- An offer has been to Cheeverstown in relation to the bungalow and we have accepted the offer.
- The resident's family are happy that the bungalow will meet their daughter's needs.
- We will discuss this move with the resident and visit the site after Christmas.
- The bungalow will be ready in October 2016. Work has commenced on building and O.T. has submitted a report about specifications and design.

**Proposed Timescale:** 01/10/2016

## **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 implemented in practice as there was no system of identifying and assessing risks in each unit.

#### **14. Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

- Each house in this designated centre will have a local Risk register (capturing health / safety / environmental risks).
- Risk policy to be reviewed and implemented.
- Training to be organised with HR and Assistant Director of Service for this designated centre.
- Risk register files are now printed and ready for each house in each designated centre. Completed (7/12/2015)
- Risk registers Excel spreadsheets for each house in each designated centre are now set up in a shared folder on the server accessible to all Persons in Charge. Completed (7/12/2015)
- Persons in Charge/PPIM will populate these risk registers and commence regular audit of health & safety environmental risks and summaries of serious individual risks in each location. Risk registers will be discussed with staff at all house meetings to ensure risk assessments and support plans are reviewed by their due date. This process to be fully

implemented by (29th February 2016)

- Risk registers will be audited during unannounced Provider/Senior Manager visits commencing from (29th February 2016)

**Proposed Timescale:** 31/01/2016

**Theme:** Effective Services

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

There were deficits in the fire doors provided in the centre.

**15. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

The fires doors will be completed in this designated centre by the end of February.

**Proposed Timescale:** 28/02/2016

**Theme:** Effective Services

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

Means of fire escape were not clearly identified in each house.

**16. Action Required:**

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

- Fire escapes have been identified with emergency exit signs.
- Emergency strip lighting is in place in each resident house
- The fire evacuation floor plans will be amended to reflect the correct fire exits.

**Proposed Timescale:** 15/12/2015

**Theme:** Effective Services

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

A safe location for residents in the event of an emergency had not been identified.

**17. Action Required:**

Under Regulation 28 (3) (c) you are required to: Make adequate arrangements for

calling the fire service.

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

Health and safety officer and the PIC and house staff will revise the Fire evacuation plan and identify a safe location for residents in the event of an emergency.

**Proposed Timescale:** 30/01/2016

**Theme:** Effective Services

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

Adequate arrangements were not in place to detect the location of a fire as it was not evident what fire zones were linked to what specific rooms/areas in the house.

**18. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

- The current fire training teaches that on hearing the bell you evacuate.
- The size of most of the community houses does not warrant a multi zone approach.
- Currently we are in the process of affixing labels to the fire panels to reflect that this is a single zone approach.

**Proposed Timescale:** 30/01/2016

**Theme:** Effective Services

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

An adequate means of escape was not available to one non mobile resident.

**19. Action Required:**

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

- Planning permission had been submitted but South Dublin County Council was not satisfied with the exit arrangements on to the road as proposed in our initial application.
- The Architect reworked the gate exit options and we resubmitted proposal on 9th November.
- We are awaiting a response from planning. This resident continues to have an active night duty as an additional support in relation to any fire evacuation incident.

**Proposed Timescale:** 30/01/2016

### **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 statement of purpose did not fully meet the requirements of the Regulations.

#### **20. 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 statement of purpose will be revised to reflect:

- The locally named advocate representative who will be accessible to all individuals in this centre. This is displayed in each of the houses.
- That active night duty is a support option within this designated centre
- The room measurements will be included in the room plan
- Admission criteria will indicate age range.
- Staff WTE will be reflected

**Proposed Timescale:** 30/01/2016

### **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:**

The roles and responsibilities of persons involved in the management of the centre were not clear and required clarification.

The systems in place to support the person in charge to manage two designated centres required review.

#### **21. 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:**

- CNM2 will return to support the PIC in this DC from the 28th of December 2015.
- A team lead will be identified in each house in this DC which will take over the local

responsibilities and will be identified in the roster from the 28th of December.

- The PIC in this designated centre is also the manager across four other designated centres. The manager in collaboration with the Director of Service and Assistant Director of service will review the PIC responsibilities across the 4 designated centres and assign responsibilities to each PIC to allow for protected time for the duties to be carried out for example one to one supervision of staff, house visits. Action to be completed by the 28th of December which will be reflected in the next roster.
- A review has commenced (30/11/16) to map out a management model, staff rostering and driven by assessed need.
- This restructuring group will be meeting weekly and have identified pilot sites to commence implementation.
- In line with the objective for this restructuring group the PIC from this designated centred has already reviewed the existing structure and identified areas of need in relation to governance and accountability. The implementation of this will be in collaboration with Finance, HR, Frontline Staff, Management and Unions. This structure will include the roles and function of each staff member.
- Meetings are documented with specific actions carried over each week. This will continue to take place weekly.

**Proposed Timescale:** 01/06/2016

**Theme:** Leadership, Governance and Management

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

The system of reviewing the safety and quality of care in the centre required improvement. For example, reports read did not include actions or improvements to be brought about and overall learning.

**22. 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:**

- Announced provider visits reports will be submitted by the end of January 2016 to include an action plan with named actions and persons of responsibility.
- These action plans will be time framed and audits will be carried out by provider nominee or a reprehensive to ensure improvements are carried out and overall learning has taken place.
- The Annual review of safety and Quality of care report will also reflect this learning.

**Proposed Timescale:** 30/01/2016

**Theme:** Leadership, Governance and Management

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

**the following respect:**

There was no annual review of the safety and quality of care provided to the residents in the centre.

**23. 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 Annual Review of Safety and Quality of Care report will be completed by the nominated provider in conjunction with the PIC in this designated centre.

This report will include information collated on the Quality database and key committees within the organisation. The data will relate to key safeguarding and assurance areas these include:

- Risk
- Health and Safety
- Health and Wellbeing
- Complaints
- Personal Plans
- Positive Supports
- Rights / Restrictions / Restraints
- Social / community inclusion

The PIC in conjunction with residents, families and nominated provider reports (unannounced visits) will generate feedback that will inform the report.

**Proposed Timescale:** 30/01/2016

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

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

Resources were not deployed within the service to ensure adequate staffing at times of the day and that the centres were managed at unit level.

**24. 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 community utilise a bank of resource hours to facilitate people who are sick, have appointments or require respite.

- Presently if a resident is unwell the scheduled staff already in place will remain until a

staff from the organisations relief panel or an agency employee is scheduled to work.

- In addition those residents attending day services are currently accommodated to go to appointments or go home early.

- The management team are reviewing staffing for this designated centre which will align rostering with the identified needs of the residents and reflect daytime coverage as part of this review. This commenced on 3/12/16.

**Proposed Timescale:** 30/06/2016

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The staffing levels during the day from Monday to Friday in the units required review.

**25. 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:**

We will develop a roster to reflect:

- The staffing requirements to meet assessed needs of the residents
- Identify the qualifications and skill mix of the staff
- Be reflective of the statement of purpose
- A weekly governance review has commenced which consists of the SIT team representative, Director of Service and CEO to review management cover and to ensure governance as per HIQA requirements. This includes appropriate PIC coverage across all designated areas and reviewing staff rosters to ensure needs are met.

**Proposed Timescale:** 01/03/2016

**Theme:** Responsive Workforce

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

There were gaps in the refresher training completed by staff in fire safety and prevention of abuse.

**26. 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 PIC in collaboration with HR and training will identify those staff who have not completed mandatory training and ensure staff schedule themselves for training at the nearest available.

- The PIC in conjunction with the HR department will identify gaps in training and incorporate more robust monitoring training deficits.
- PIC and management will identify expiry dates for training and flag in advance to staff.

**Proposed Timescale:** 01/02/2016

**Theme:** Responsive Workforce

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

The was no system of supervision of staff in the centre.

**27. Action Required:**

Under Regulation 16 (2) (b) you are required to: Make available to staff copies of standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

The line of accountability (including roles and responsibilities) from PIC down will be identified in each house in this designated centre. This will also include a one to one supervision.

- Through the performance management system each (number of staff) staff will receive one to one supervision.
- An annual performance review will be completed with all staff members

**Proposed Timescale:** 31/01/2016

**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 finance policy required review.

There was no infection control policy.

**28. Action Required:**

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

- Infection prevention and control policy out for consultation and changes to be completed. Next step is board approval. On receipt of board approval implementation plan will be drawn up to include –Dissemination of policy, establishment of core team for the development of training materials to support implementation and communication (presentation, summary leaflets and FAQ. Update/refresher training for staff. Timeline need one month from board approval to commencement date and then finish date will be 6 - 8 weeks for residential staff Challenges –numbers of staff to train
- Review completed on Prevention of Abuse Policies clarified that it is compliant with the National Policy on the Safeguarding of vulnerable adults.
- The financial policy has been reviewed and amended and awaiting sign off by the Board as per process.

**Proposed Timescale:** 31/01/2016

**Theme:** Use of Information

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

Residents records were not easily accessible as their information was held in up to five folders with large volumes of information.

**29. Action Required:**

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

New revised Personal Plans will consist of one comprehensive plan with a second folder having supporting documentation relevant to that calendar year.

**Proposed Timescale:** 01/03/2016