<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Cheeverstown House Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004926</td>
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<td>Centre county:</td>
<td>Dublin 6w</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Cheeverstown House Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Paula O'Reilly</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sheila McKevitt</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>14</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 10 November 2015 09:30 10 November 2015 18:00
From: 11 November 2015 09:30 11 November 2015 15:00

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

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Summary of findings from this inspection
The Health Information and Quality Authority's (the Authority) unannounced inspection was undertaken to follow up on the submission by the provider, following a notice of proposal to refuse and cancel this centre's registration. The Authority had issued a written notice of proposal to refuse and cancel registration of the centre following significant failings identified at the most recent announced registration inspection on the 21 and 22 April 2015. At that inspection a significant number of non compliances were identified and 31 actions required. The high level of non compliances were discussed with the provider nominee at a number of meetings in the Authority offices following the inspection.

There were 14 residents in the designated centre during the inspection which forms part of a larger residential campus. The centre consists of three units (to be called houses in the report): two bungalows and one two story house. Some of the residents were out all day at various activities and day services, therefore not all of
the residents were met. During this inspection, inspectors met with residents, staff members and management staff. Inspectors met with the new nominated provider and discussed the response to the above proposal and to review implementation of the proposed actions.

Overall, inspectors found that there was significant progress made since the previous inspection. Since then, a person in charge had been nominated to oversee the service. The quality of residents' lives had been improved by the relocation of some residents to more suitable accommodation that met their assessed needs. A service improvement team had been set up to drive change and improvement across the organisation and the centre.

The premises and documentation were reviewed by inspectors and care practices were observed. The residents all had an intellectual disability and many residents required a degree of support and assistance with their activities of daily living and individual care. Inspectors found that a number of changes had been made to enhance the quality of life of residents. This applied to residents who had exhibited behaviours that challenge. Incidents of alleged peer abuse had decreased and inspectors were informed a number of residents, who were non compatible, were now living in separate settings. In addition, training for staff had focused on understanding the reason for the behaviour and on promoting de-escalation techniques. Inspectors found the privacy and dignity of residents living in the centre had significantly improved. However, there were still five residents living in two multi occupancy bedrooms.

There were systems in place to safeguard and protect residents from abuse, with a designated person assigned responsibility in this area. However, training for staff required improvement. There were good practices to support residents with responsive behaviours and also to transition within the service and into the community. Residents had a range of interesting things to do during the day, although these were mainly based on the campus. Residents' information was available and maintained in their homes, however the overall documentation, development and review of residents' personal plans required review. Due to the size and layout of residents' files, information was not easily accessible.

There was a person in charge of the centre nominated since June 2015. He attended a fit person meeting in the Authority's offices in July 2015 and demonstrated adequate knowledge of the Regulations. However, improvements were required to ensure effective governance at centre level as the person in charge also oversaw another designated centre, and could be called on to cover the management of two other designated centres on the campus and four in the community. Inspectors found staff meetings were taking place, although there was no system for formal supervision of the staff.

The monitoring of the quality of care provided in the centre also required improvement and there was no annual review of the safety and quality of care in the centre carried out. These matters were discussed with the senior management at the end of the inspection and at the feedback meeting. They assured inspectors these issues would be reviewed and that improvements would be carried out to address
them.

There were 31 actions from the previous inspection reviewed. 17 actions were completed, 14 were not addressed.

These and all other matters are outlined in the report and Action plan 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 that some residents’ rights were respected. Improvements were required in relation to the complaints policy, the management of complaints, maintaining residents’ privacy and dignity and consultation with them regarding how their home was run and making choices.

The centre was managed by staff with little consultation from residents. There were no regular house meetings taking place in any of the houses. Involvement of residents was limited to the weekly house shop and their food choices. Inspectors saw private information in relation to a number of residents displayed in communal areas. Also, staff notices and information pertaining to them was displayed in communal rooms although there was a staff office in each of the houses.

The centre had information including contact details of the National Advocacy Committee on display in the houses together with lots of information about their rights. In addition, a number of residents told inspectors they had an internal advocacy representative and showed inspectors a photo of the advocate and dates of upcoming meetings which were on display in each house.

Staff in all houses were not aware if those residents who had the capacity, were registered to vote and it was not recorded in their file. Inspectors were informed that staff were not always available to assist residents to exercise their right to vote when an election was taking place although there was a voting centre on site. This will be discussed further under outcome 17.
Care provided was based on routine and not person centred. The residents' day was based on the availability of staff, access to the bathrooms and being ready for day service. It was not reflective of their needs or the personal plans of those that had them completed. For example, staff in one house explained to the inspector that as they had only one bathroom for seven residents, two had to have a bath/shower prior to going to bed otherwise they would not have all seven residents have them ready in time for daycare in the morning.

Many of the staff spoke of lack of a staffing attributing to the residents' lack of access to activities that are meaningful and purposeful and reflected their interests and capacities. The centre was located close to a number of churches which residents could access. Residents were facilitated by staff to attend. However, staff told inspectors that this was infrequent due to staff shortages.

Staff were not facilitated to maintain residents' privacy during the delivery of intimate care. 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 in some of the houses residents used a toilet in a cubicle while other residents had a shower behind a curtain in the same room. This is outlined in outcome 6. It had been identified but not changed since the inspection in April 2015. Also, there were no privacy locks on a number of bedroom doors in the houses. Therefore, residents could not independently maintain their own 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 or legislative requirements. The policy did not clearly identify the person nominated to deal with complaints in each house, the appeals person or the person responsible for reviewing complaints. Inspectors were told that there were no complaints in any of the houses and no complaint record forms available to staff in the houses.

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 inspectors were found to be correct with receipts in place for all expenditures. Staff had systems in place to check each resident's balance. In addition, there were audits carried out by the management team and finance departments. The centre was in the process of ensuring that each resident had their own bank account.

**Judgment:**
Non Compliant - Moderate

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**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 communicated well with residents and they understood their individual ways of communicating. Residents appeared confident in making themselves understood.

Residents had access to portable house telephones, televisions and radio. Some also had access to mobile phones as was their choice. However internet access was not provided to residents to enhance their communication. There were no assistive technology or aids and appliances available for any resident to support their communication needs and promote their full capabilities.

Information on display in the houses was not always available in a format that could be understood by all residents. For example, some were displayed too high for wheelchair dependent residents to read, the font was too small for some residents to read and for those with little literacy skills there were no pictures or easy read format that would support these residents to understand.

Judgment:
Substantially 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
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. Upon 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 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 stated. 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 representative 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 an intellectual and/or physical disability. Inspectors reviewed the personal plans of two residents.

The personal plans for residents' social care needs were called "personal outcome measures" (POMs). A small number of residents had a POM assessment completed by a key worker in consultation with the resident. The sample of completed personal plans reviewed were holistic and focused on a varied aspect of the resident's life, such as meeting their friends more frequently. There were monthly evaluations of the residents’ goals however these were incomplete, often limited to discussing one goal. In addition there was no evidence of multi-disciplinary input, resident involvement in the review or of whether residents goals were being met. Those completed POMS were not in available in a format accessible for residents to understand. These issues were identified at the last inspection and not completed. Also, new personal plan documentation was seen by inspectors which was expected but had not yet been rolled out across all houses.

Residents had detailed assessments completed where their healthcare needs were identified. However, residents who had healthcare needs identified on assessment did not have a corresponding care plan in place. For example, one resident was identified as at risk of developing pressure ulcers, high-risk of falling and had restraint in use and had no care plans in place to reflect these 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 to a variety of activities including the weekly onsite disco. However, the activities accessible to them were mainly those available on the campus hence, they had little or no opportunities to link in with the local community.

Residents' records were contained within five large folders; therefore it was difficult to identify the most up-to-date information on each resident. This is discussed further under Outcome 18. Inspectors were informed that work was taking place on removing excess information from residents’ files.

**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:
The three houses were found to be clean and tidy. They were well heated, had good natural light and were somewhat homely. However, two of the three houses had bathroom/toilet facilities which did not meet the needs of the residents living in both houses. Also, residents in one of the houses lived in multi occupancy bedrooms.

In one of the houses, there was one multi occupancy and one twin bedroom each with wash hand basins. Although the number of residents in shared bedrooms had decreased staff and residents still had to walk past one bed space to get to the bed space/s to the rear of these bedrooms. There was now appropriate screening around each bed however, there was not much space in the bedrooms.

The location and insufficient numbers of bathrooms and assisted toilets impacted on residents' privacy, dignity, choice and quality of life. The bathrooms were located off the living area where residents could be seen from getting dressed. The bathroom consisted of a bath with a shower curtain, and a walk in shower, also with a shower curtain, a sluice, a ceramic sink, two cubicle toilets which are very narrow, and not wheelchair accessible. This impacted on residents' dignity as all wheelchair bound residents' could not access the toilet. Staff told the inspector that when one resident is having a shower, and another resident is having a bath at the same time that they ensure the shower curtains and the curtains around the bath are used. There were residents with medical problems who require frequent and immediate access to the bathroom. As residents had access to only one bathroom this meant that residents may have to use these toilets when other residents are having a bath or shower.

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:
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.

A risk management policy was seen by inspectors that met the requirements of the Regulations. However, the policy was not fully implemented in practice. While a safety statement was seen and it included the environmental issues in each house, risk assessments on the environment and work place at unit level had not yet been carried out or any control measures to mitigate any risks. This had been an action at the previous inspection and was not addressed. The assistant director of services described the plans to address this. Five draft risk registers had been developed for houses in the campus. These were seen by inspectors. Once the risk registers were developed for all houses, they would be maintained and updated at local level. Since the last inspection, staff had completed training on risk management and this was confirmed by staff.

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.

There were systems in place to report and respond to incidents in the centre however, this required improvement. A risk assessment form was completed by staff who risk rated the incident. The forms were then sent to the person in charge for review who in turn sent it to senior management. However, follow up action was not clearly communicated with staff at centre level and incident forms were not consistently returned. Therefore it could not be ascertained what change had been brought about and learning for staff. This was an action at the previous inspection and required improvement.

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. Furthermore, some practices at local level were not adequate for example, the use of disposable sponges.

There was an organisation wide emergency plan and staff were familiar with it. Each resident had an individualised evacuation plan developed also. Inspectors read that a resident required the support of two staff to mobilise from bed into a wheelchair, although there was only one staff based in the house at night time. However, since the last inspection, an additional two floating staff were available in the centre at night time to support the night manager. This arrangement would ensure staff would receive support if an evacuation was required.

There were procedures in place on the management and prevention of fire. In each house fire procedures were prominently displayed. There was evidence that fire safety training had been provided to staff, with some gaps identified as some staff had not completed up-to-date refresher training. All staff spoken to knew what to do in the event of a fire. There were regular fire drills and unannounced fire evacuations were
carried out by staff at suitable intervals, including night time. Inspectors read records of fire drills carried out and they included learning outcomes. The drills were also reviewed at the health and safety meetings.

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.

Since the last inspection fire doors had been installed in one house in the centre. However, fire doors were not yet installed in the remaining houses. A list of the areas where deficits were identified was forwarded by management after the inspection. Inspectors were assured by senior management that these works were being prioritised and will be completed by March 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse.

There was a policy on safeguarding residents from abuse which contained guidelines on how any allegations of abuse would be managed. The provider submitted an update following the inspection that clarified the policy referenced the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. However, it did not fully guide practice. For example, the role of the person in charge was not clearly described and it did not state who was responsible for notifying allegations of abuse and submitting follow up actions to the Authority. A draft procedure was later shown to inspectors which was expected to clarify this. This is discussed in Outcome 18.
Inspectors did not meet the person in charge or managers deputising for the person in charge as they were on leave. A nurse manager was covering the management of the centre in their absence. She was familiar with the types of abuse and the internal reporting arrangements in place. However, as outlined in the paragraph above, the responsibility of managers was not clear. As mentioned above 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. However, up to half of the staff in the centre had not completed refresher training, this is discussed under Outcome 17.

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 to guide care. However, some were too vague and not person centered. For example, one resident had two intimate care plans. An out of date version was on their file, and the up-to-date version was located in a separate filing cabinet.

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. There was evidence that the GP, psychology and psychiatric services were involved in the care as required. The planned care was clearly outlined in the residents' positive support plan. The support plans reviewed were person centred and guided staff practice on how to manage the behaviours. However, where residents were prescribed and administered as prescribed (prn) medications for the treatment of behaviours that challenged this treatment was not reflected in their behavioural support plan. Residents who had communication passports also had their behaviour support plans recorded there.

There was very little use of restrictive practices in use in the centre. These were limited to bed rails and lap belts. Inspectors read risk assessment completed, and there were checks carried out by the staff when these 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 were reviewed at the rights committee.

**Judgment:**
Substantially 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):

Findings:
There was evidence that the healthcare needs of residents were being met. However, improvements were identified in relation to records such as 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. There 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 at risk of developing pressure ulcers did not have a detailed care plan in place to reflect the care required. This was actioned under outcome 5.

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 to 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 and the 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 residents with specialised dietary requirements had these needs met. For example, one resident had diabetes, and staff were familiar with the resident's needs and supplied the resident with a diabetic diet. 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):
Some action(s) required from the previous inspection were not 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, there were no room measurements written in and they could not be identified from the room plans included. The organisation structure and whole time equivalent of staff were not reflected.

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:
There was a person in charge nominated since the last inspection. The person in charge was suitably qualified, experienced and full time in his role. This action plan from the previous inspection had been completed. An interview had been held with the person in charge in the Authority offices in July 2015 during which he demonstrated knowledge of the Regulations and his responsibilities therein. The person in charge was on leave during the inspection.

Inspectors found the systems in place to support the person in charge were not adequate. A nurse manager was deputising in the absence of the person in charge as other managers of the centre were on leave. This nurse manager was overseeing two designated centres, but was also responsible for another two designated centres on the morning of the first day of the inspection. Inspectors did not observe the manager in the houses, or meeting staff and residents. Later in the inspection, this person spoke to inspectors and outlined her role and responsibilities. She primarily oversaw the completion of the rosters for the two designated centres and arranging cover for unexpected leave. This took up the majority of her time. Inspectors found this arrangement was not adequate and it was evident this was having a negative impact on the quality of the service as evidence in the report and outlined below.

The centre was operated by the Cheeverstown House Limited. There was a senior management team which included the provider nominee (manager of quality and strategic planning) who was new to the role since 2 November 2015. In addition, the director of services, assistant director of services and other heads of department within the organisation were on the team. 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 full compliance with the Health Act 2007 (Care and Support of Residents in Designated Centre’s 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,
- the centre was not adequately resourced at certain times of the day,
- staff were not formally supervised,
- managers overseeing the centre were not fully supported in their role,
- there were no lines of authority clarified at unit level in the centre

Inspectors read reports of unannounced visits to one unit in the centre. The findings were outlined however, the action plan did not consistently address the finding and persons were not delegated to address the issues identified. This was discussed with the provider who assured inspectors the findings were discussed in detail at person in charge meetings and the documentation of the reports would be reviewed to contain
more detail. It was expected that unannounced visits of all units in the centre would be completed before the end of the year.

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 was not addressed.

**Judgment:**
Non Compliant - Major

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

**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 that the needs of residents were met.

Inspectors found resources were not effectively deployed to support residents' individual needs. For example, staff told the inspector that there were not enough staff to meet the hygiene needs of seven residents each morning therefore, they attended to two residents hygiene needs the night before. Also, inspectors saw that residents attended activities in the evenings and weekends on an ad hoc basis, staff stated that this was due to poor staffing levels and the non availability of transport.

The specialist equipment which was not in a good state of repair during the last inspection had now been repaired. Residents who required, wheelchairs, pressure relieving equipment and low-low beds had them in place.

**Judgment:**
Non Compliant - Moderate

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**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
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 certain times of the day in parts of the centre and the 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 were knowledgeable of policies and procedure which were available to them in the centre.

As reported in outcome 16, some of the houses did not have sufficient resources of staff to ensure residents’ needs were being met to a high standard in the mornings, evenings and at weekends.

There was a planned roster read by inspectors. However, the rosters did not include the full names of persons, grade and if they were agency or relief staff. See outcome 18. In addition, the person in charge and management were not included in the roster. Staff did not know who to report to until a manager called the house to inform them.

There were no formal arrangements for one-on-one supervision meetings in the centre. This had been an action on 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 human resources team showed inspectors training scheduled of all staff training completed to date in the centre. The person in charge ensured all staff in the centre was provided with access to mandatory training including fire safety and protection of vulnerable adults. However, records read showed up a number of staff had not completed training in the prevention of abuse in over two years, and some had not completed fire safety training in over one year. HR explained to inspectors the action that was taken to address this matter.

The staff had also completed training in movement and handling of residents, first aid, CPR, and the safe administration of medication. In addition, some staff had completed
training in eating and drinking training, infection control and epilepsy awareness. 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 Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**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 reviewed this outcome in relation to documentation for residents, policies and staff rosters. 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. Inspectors found the documentation, maintenance and accessibility of residents’ information required improvements. There were up to four folders per resident, with large volumes of up-to-date and historical information. Therefore it was difficult to identify residents’ most pertinent and up-to-date healthcare needs and specific wishes. New documentation was being introduced across the organisation which was anticipated to address this. This work is acknowledged by inspectors. However, further improvement was still required. See Outcome 5.

At the previous inspection all policies and procedures required by the Schedule 5 of the Regulations were reviewed. The provider had ensured the designated centre had all of the written operational policies required. While all policies were in place improvements were identified. For example, there was no infection control policy. The complaints policy did not reflect practice (see Outcome 1). The policy on the prevention of abuse did not fully guide practice (as outlined in Outcome 8).

As reported in Outcome 17, there was a roster in place. However, the roster did not
include staff names, grade, the person in charge or members of the management team.

**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
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Cheeverstown House Limited</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0004926</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>10 and 11 November 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>14 December 2015</td>
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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 were not been consulted with about how their home was being managed.

1. **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,

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:
• Bi-monthly PIC meeting to commence with specified agenda, agreed actions and time framed.
• Resident meetings to involve wider consultation to demonstrate greater choice in house decision making.

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:
There were no privacy locks on residents bedroom doors.

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:
• Privacy is an issue 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 by the keyworker and personal Outcome measures Planned Co-ordinator.

Proposed Timescale: 31/03/2016
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.

3. 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 include this.
- Folders to be put in place for Eating / Drinking / Swallowing guidelines. These are kept in each kitchen.
- Staff information will be kept in the office and not in communal areas.

**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:**  
Access to activities was dependent on availability of staff and access to day services rather than the wishes and needs of residents.

**4. 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:  
- Staff roster should be based on the assessed needs of the individual in the house and reflect personal choices and meaningful engagement.  
- A needs assessment to be completed in relation to personal care and hygiene and ensure that arrangements are documented to maintain dignity and respect is maintained.  
- Work schedule to be completed and actioned for the Beeches residential campus to improve bathroom facilities and bedrooms.

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

**5. 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:  
- Policy and procedure will be updated to ensure clear information on the procedure to record and fully investigate each complaint.  
- There will be a nominated person who will deal with issues at local/house,
The procedure will include template to document nature of complaint, person responsible for managing complaint, details of investigation, related actions taken, response to complainant, satisfaction level for complainant and if further action required.

Implementation and communication plan for the updated policy.

Complaints policy will be amended to reflect local complaints folders in each house.

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

### Outcome 02: Communication

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The manner in which information for residents was displayed did not support them to interpret the information.

**6. Action Required:**
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents’ needs and wishes.

Please state the actions you have taken or are planning to take:
- Information will be displayed at a level which will allow residents using wheelchairs to access information.
- The information will be printed in a font which is accessible (recommended font is 12).
- The residents with limited literacy skills require easy to read or pictorial format.
- All communications for residents to be reviewed and made accessible based on assessed need.
- To be completed by manager and keyworkers in each of the houses.

**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:
Residents in none of the houses had access to the internet.

**7. Action Required:**
Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

Please state the actions you have taken or are planning to take:
- PIC and keyworkers to review with each individual resident their access to the
telephone, television, radio, newspapers and internet.

**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 was no evidence that residents were being facilitated to access assistive technology and aids and appliances to promote their full communication capabilities.

8. **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:**  
- Speech and Language therapist has commenced assessment within the designated centre and will be addressing AT assessment for communication based on the assessed needs of the individual residents.  
- Occupational therapy manager and Speech and Language therapy Manager will meet on the 15th of December to discuss the process presently in place for assessment and documentation of Assistive Technology and review.

**Proposed Timescale:** 31/12/2015

**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 admission policy did not reflect admission practices.

9. **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:**  
- Resident and Next of kin involvement in initial house visit, decoration 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  
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.

10. 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.

11. 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  
• Memorandums to be signed by the PIC, Residents or Representative

Proposed Timescale: 01/03/2016  
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.
12. **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.
- This will include what utilities will be paid and any other additional charges.

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

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**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:**
Health care plans were not developed for residents identified health care needs.

13. **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:**
- Healthcare Plans have been included in the revised personal plans which are being piloted in 3 designated centres. 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.
- These plans will be reviewed at a minimum of 3 months and rewritten every 12 months by the identified house lead.

**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:
The review of residents' personal plans did not include evaluation of the effectiveness of the plan.

14. **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:**
- We have developed a system where the MDT input is identified in the Standard Operating Procedure for the "Compiling, Maintaining and Reviewing a Personal Plan".
- The key staff working with the resident will ensure that this is included in the personal plan. The PIC and planned coordinators will be required to review personal plans as needed or at a minimum of 6 months to ensure this MDT input are captured.
- The revised Personal Plans being implemented will include plans of care involving MDT input and be documented in the personal care plans and signed off.
- At present the MDT input for residents is captured on the quality database. This database collates information based on each resident in the designated centre in the following areas:
  - Mental health and ID
  - Positive Supports
  - Communication
  - Complex needs.
- All PICs have access to this database to inform them of those individuals receiving MDT support services.
- A meeting was held with all PIC’s and managers on the 23/11/15 to communicate that collaboration with the MDT is required when reviewing personal plans and to document same (evidenced in minutes of meeting).
- A date is being confirmed to meet with all clinicians to discuss their role in the review process, signing off and attendance at planning meets for residents.
- Clinicians are also updating all information on the quality database for PICs to access.

**Proposed Timescale:** 31/03/2016

**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 evaluation of the effectiveness of the plan.

15. **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 quality department is linking with the PIC in this designated centre to identify
those personal plans completed for each resident.
  • The information from the Personal Outcome Measures plan will be audited and inputted into the quality database. As part of the audit it will include whether goals have been achieved and how effective was the outcome for the resident.
  • The quality department is presently reviewing the Personal Outcome Measures process and plan to ensure that all 23 outcomes which relate to all aspects of the person’s life is reflected in the plan and the goals identified for that person and their effectiveness. This will be delivered for 2016 and training attached to same.
  • It will commence in this designated centre in January 2016.

Proposed Timescale: 01/06/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient numbers of showers and toilets to meet the needs of residents. The location and layout of bathrooms and toilets did not not support the dignity of residents.
Multi occupancy bedroom rooms did not support the dignity of residents.
The limited space between beds and the layout where residents faced each other did not respect residents' personal space or privacy.

16. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
Renovations are currently taking place within the campus to address bathroom privacy issues and bedroom occupancy within these residential areas.
• The plan for this home is to reduce double and triple occupancy to single bedrooms.
• To create privacy for the shower and bathing areas.
• In the short term rosters within this house will be reviewed and routines relating to personal hygiene and intimate care needs will be based on individual needs assessment and not dictated by the day service schedule.
• Roster review to be completed by the DOS, ADOS and PIC for this designated centre to ensure a routine which is responsive to individual needs.

Funding is presently being confirmed with the HSE for this residential home (one home has been completed and one under way) if funding is not forthcoming a proposal for these individuals to be transferred to the newly renovated respite home within this residential area will be made.
### 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.

**17. 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 has commenced with over a 100 staff trained across the organisation with the aim of full implementation by the end of April 2016.

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**Proposed Timescale:** 30/04/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence of follow up action to be taken or learning for staff when incidents occur in the centre.

**18. 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:
- Any serious risk incident or adverse event scored ≥ 9 requires a new or reviewed risk assessment to be completed and appropriate support or control measures planned to minimise the likelihood of reoccurrence or to reduce the impact of a reoccurrence.
- These serious risk incidents or adverse events and supports/control measures will be identified in the person’s Individual Safety Plan.
- The house Service & Care provision and Health & Safety Risk Register is a summary of the serious risk incidents and adverse events identified and their supports/control measures used as an audit tool.
- Local Managers and frontline staff refer to the house Service & Care provision and Health & Safety Risk Register as a set agenda item at every house staff meeting and discuss and review the learning from the identified risks and supports/control measures.
• The house Service & Care provision and Health & Safety Risk Register is audited during unannounced Provider/Senior Management visits
• Risk is discussed as a set agenda item at Provider/PIC meetings

**Proposed Timescale:** 01/03/2016  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Inspectors found some infection control practices were inadequate.

19. **Action Required:**  
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

**Please state the actions you have taken or are planning to take:**  
- A draft Infection control policy is now being circulated and as per policy is awaiting sign off by the Board.
- Personal care procedures and practices in all the houses have been reviewed referencing best practice for infection prevention and control.
- In consultation with managers and staff new procedures and practices have been adopted and are currently being implemented. For completion December 18th 2015

**Proposed Timescale:** 30/01/2016  
**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 in some houses in the designated centre.

20. **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:**  
- Fire doors will be completed in this Designated Centre by end of February 2016

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

**Outcome 08: Safeguarding and Safety**  
**Theme:** Safe Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Therapeutic interventions used to manage some residents behaviours that challenged were not included in their behavioural support plan.

21. **Action Required:**
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

**Please state the actions you have taken or are planning to take:**
- As per the Medical Policy and Restraints and Restriction Policy (to be signed off) “Medication can be used in cases of emergency when prescribed by a doctor, or for certain behaviours as a last resort where there is evidence that it may be effective, and staff have followed protocols in relation to prn medication use, which will reference positive support and mental health care plans as relevant”.
- The PIC in this designated centre will liaise with keyworkers in each house to review the positive support plans in place and will include on the plan were a PRN (therapeutic intervention) for person in distress may be indicated.

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

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**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.

22. **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 reviewed. This revision will include information on room measurements, room plans organisational structure and WTE staffing.

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

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**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

23. **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:
- 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.
- A review has commenced (30/11/16) to map out a management model, staff rostering and role profile to be driven by assessed need. The line of accountability (including roles and responsibilities) from PIC down will be identified in each house in this designated centre.
- Two pilot sites have been identified to commence this.
- This will be reflected in the Standard Operating Procedure for Governance and Management and the Statement of Purpose

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

**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 for all findings in them, what improvements were to be brought about and overall learning.

24. **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 service provider action plan will clearly identify the actions required and persons responsible for the action. These actions will be on the agenda for the person in charge meetings
### Proposed Timescale: 29/02/2016

**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.

#### 25. 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.

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### Proposed Timescale: 31/01/2016

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### 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 staff resources were not adequate to meet the needs of residents at all times.

#### 26. 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:**
- As part of the pilots being implemented a needs assessment of each individual will be
completed in this designated centre and this will be reflected in the roster.

• The SIT (HSE service improvement team) continues to work in collaboration with Director of Services and Assistant Director of resources to modify rosters to suit the needs in particular in relation to morning, evenings and weekends.

Proposed Timescale: 31/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staffing levels required review.

27. 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 Roster will be completed every 2 weeks. The roster will include name, staff grade and hours worked.
• It will identify the PIC who is on duty at that time.
• This will be reviewed by the team that it reviewing the staff and manager rosters weekly (as described in Outcome 14).

Proposed Timescale: 14/12/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were deficits in the refresher training completed by staff in fire safety and prevention of abuse.

28. 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 will identify those staff who need to complete mandatory training in Fire Safety and Prevention of Abuse and schedule this training for the nearest available dates.
**Proposed Timescale:** 15/12/2015  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
There was no system of supervision of staff in the centre.

**29. Action Required:**  
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:  
- The PICs and PPIM will meet staff on a one to one supervision once a quarter and document.  
- There will be an identified house lead who will also meet with house staff on a weekly basis around supervision. The CNM 1 will complete supervision with the house lead and the PIC/CNM3 will complete supervision with the PPIM’s on a monthly basis.

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**Proposed Timescale:** 30/04/2016  
**Theme:** Use of Information

**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 and prevention of abuse policies required review.  
There was no infection control policy.

**30. 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 control policy is now complete and is awaiting sign off by the Board.  
- 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.

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**Proposed Timescale:** 30/01/2016  
**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 four folders with large volumes of information.

31. **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:**
- New revised Personal Plans will consist of one comprehensive plan with a second folder having supporting documentation relevant to that calendar year.

**Proposed Timescale:**

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in the information required to be included in the staff roster.

32. **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:**
- Rosters will include full names of persons, grade and if they are agency or relief staff.
- Who is in charge in the house
- A new template is being developed to capture this information.

**Proposed Timescale:** 22/01/2016