<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-0004925</td>
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<td>Centre county:</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<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>Helen Lindsey</td>
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<tr>
<td>Support inspector(s):</td>
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<td>Type of inspection</td>
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<td>Number of residents on the date of inspection:</td>
<td>11</td>
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<td>Number of vacancies on the date of inspection:</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 09:00  To: 10 November 2015 17:45
From: 11 November 2015 09:00  To: 11 November 2015 14:45

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

| Outcome 01: Residents Rights, Dignity and Consultation |
| 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 11: Healthcare Needs |
| Outcome 12: Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 15: Absence of the person in charge |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

Summary of findings from this inspection
This unannounced inspection was carried out to follow up on the high level of non compliances that were identified during the last inspection. Inspectors assessed whether the commitments made by the provider to improve the service were being carried out in the agreed timescales. It was identified that progress was being made to improve the quality of life for residents and plans were in place for further improvement. However further improvements were required in the governance and management of the centre.

Four designated centres that make up the campus were inspected on the same day therefore this report reflects some of the overall findings related to all centres such as governance and management.

The designated centre is made up of two bungalows and 2 two story houses. During
this inspection, inspectors met with residents, staff members and management staff. Inspectors met with the new nominated provider and discussed the matters described above and reviewed the implementation of the proposed actions. The premises and documentation were viewed and examined by inspectors and care practices were observed.

On the day of inspection there were 11 residents in the designated centre and they all had an intellectual disability. Six other residents had moved out of the centre temporarily while renovation works were taking place.

Overall, inspectors found that there was improved compliance with the regulations, which had a positive impact on the lives of some residents:

- A person in charge had been nominated to oversee the service.
- The quality of residents' lives had been improved by the relocation of residents to more suitable accommodation that met their assessed needs.
- The premises were being renovated, and décor and maintenance had been improved.
- Staffing levels supported residents to engage in a range of social activities.
- Individual risk assessment were in place for all residents.
- Clear transition plans for those moving out within the centre or to other places.
- A service improvement team had been set up to drive change and improvement across the organisation and the centre.

Generally improvements had been made in respecting residents privacy and dignity. Plans were in place to address outstanding areas that impacted on residents including addressing the multiple occupancy bedrooms and multipurpose bathroom areas. However, in a small number of cases residents dignity was not being maintained and they were not being fully safeguarded. The provider was aware of this and was taking action.

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 and timelines for investigations required improvement.

Residents had a range of interesting things to do during the day, although these were mainly based in the campus itself. Residents' information was person centred, available and maintained in their homes. However improvements were needed in involving residents and also reviewing plans to ensure they remain up to date.

Some improvement had been made with the accessibility of the complaints policy, however the practice in the centre required improvement. Practice also required improvement in relation to implementing the risk assessment policy.

There had been a person in charge of the centre since June 2015. During the previous inspection she was found to have demonstrated adequate knowledge of the Regulations. Inspectors found staff meetings were taking place, though a formal system of staff supervision had yet to be put in place.
Other areas where the provider is required to improve include the admissions policy, the contract of service, management and learning around incidents and accidents, fire safety, mandatory training for staff (fire and protection of vulnerable adults), providing an up to date statement of purpose, and staff rosters. 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 senior management at the end of the inspection and at the feedback meeting. They assured inspectors these issues would be reviewed and measures taken to address them.

All 24 actions from the previous inspection were reviewed. 10 actions were completed, eight were in progress and five 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:**

There had been a number of significant improvements since the last inspection, however some issues remained that meant not all resident’s had their rights and dignity well maintained.

There was some evidence that residents and relatives had an opportunity to contribute in how the centre was planned and run. Inspectors found that residents’ wishes were progressed to board level through the parents on the board of the centre.

Information on the internal and external advocacy services were available on the notice boards in each of the units.

There was limited evidence of residents and their representatives being involved in planning their health and social care, for example at the annual review meeting. This could be improved, and the action is made under outcome 5.

Residents were seen to be spending time in their houses as they chose, and being involved in social activities of their choice. Some areas of the centre had been redecorated and residents were involved in making choices about their homes.

Resident’s bedroom areas were seen to be personalised, and reflected their personal choices for colour, and had their own belongings around them such as pictures.

During inspection, all of the staff were seen to treat residents with dignity and respect.
Staff were seen to know the residents’ needs well, and interacted with them in a positive way, or leave them to have their own space if this was their preference. Staff were clearly committed to ensuring the residents had a good quality of life.

All residents had a weekly schedule that set out their activities. Some attended day services or work opportunities offered by the provider, and others had a person centred plan for how they spent their days, based around the house they lived in.

Staff spoke about resident’s personal interests for activities outside of the centre. Residents all had the opportunity to access the local community including trips to the supermarket, visiting family members, going to the local shops and going out for meals with support.

There had been a number of residents moving between the units on the campus. In one example seen this had been a significant improvement for residents in the unit. The change in the environment and their confidence was a positive outcome for them. However, another change had a negative impact on the quality of life of one resident. Concerns had been expressed by the resident, staff and family members. Action was being taken to resolve this matter, including monitoring any incidents in the unit, steps to safeguard the residents, providing different space for residents to use if needed, and exploring alternative housing options.

Significant work was being carried out on one unit, to alter the bathroom to provide separate areas for showering and bathing. The result of the changes would be more privacy for the residents when using the bath, shower and toilet facilities. One other unit still had a large bathroom, that was very cluttered. This would not have provided a pleasant and relaxing environment for bathing, however, the plan was for that unit to undergo renovation when other works in the centre were complete.

One bedroom had three residents sharing which meant they had very limited opportunity for privacy, and it was difficult to maintain their privacy and dignity in meeting their care needs. Although the rooms were partitioned in to four areas, the spaces were limited, and although there were curtains for privacy, noise levels were seen to carry to all areas of the room. As above, this unit was due for renovation to provide single and double bedrooms only.

Although there were improvements in the area of complaints, the process was still not being followed clearly, and staff were not familiar with how complaints were being dealt with. The policy did not reflect the practice in the centre or legislative requirements. For example, the person nominated to deal with complaints in each house, the appeals person or the person responsible for reviewing complaints were not identified. There were no records of complaints in the units, however two examples were given where staff thought that family members had made complaints. They were not aware of the progress of those complaints. In one case there was very clear evidence of the policy being followed, with options being explored for resolving the issue. There was no record of the other possible complaint, so it was unclear if it had been made.

Support plans showed that staff facilitated residents to exercise religious rights. Residents were supported to access mass in the local church. Some attended services
with their family.

Staff supported residents to retain control over their property and where small amounts of monies were held by the centre there was a transparent procedure around this to protect both residents and staff.

Residents did now have a bank account in their own name. Once account details and cards had been received, the move would be made to pay residents monies such as pensions or disability allowance were paid directly in to their personal bank account.

The provider was exploring the options to make wifi available on the campus. In the short term portable hotspots had been made available for those who wanted them.

Inspectors were informed that the campus served as a polling station during elections and residents could vote.

Judgment:
Non Compliant - Moderate

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 still required further review.

The admission policy had been reviewed in March 2015. On reading it, inspectors found it did not reflect the 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 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. This action
remains outstanding from the previous inspection.

**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 residents had a personal plan available that was person centred and
set out their individual needs and other professionals were involved in providing support
to the residents. However, improvement was needed in consistency of setting and
achieving plans and goals for residents. Review and update of assessments and
residents plans also needed to improve to ensure residents received the care and
support they needed.

For each resident there was a detailed personal plan, safety plan, health plan and
intimate care plan. These were supported by assessments from a range of professionals,
and in most cases there was clear guidance on how resident’s needs were to be met.
For example speech and language therapy, psychiatry and psychology assessments with
recommendations.

However, two examples were seen where dietician advice had been given, this is
detailed in outcome 11.

In one example seen, a recommendation had been made to ensure safety linked to
changes around staffing but it had not been implemented. Inspectors saw that the
staffing had changed, but the recommended safety alarm had not been fitted in the
unit. Although no incidents had occurred, there were risks for the resident, and this was
clearly described in the risk assessments that described the need for the action.
Inspectors found that many of the resident’s plans were not dated. Therefore it was not possible to see if they were current, or had been reviewed regularly. This is the same as the finding at the last inspection.

There was a process in place for ensuring residents had meaningful opportunities in their lives, which included setting goals and aims for the future. Goals were person centred and were different for each resident, however, it was not clear if anyone other than the resident's key worker was involved in making plans, as the records did not clearly indicate how the resident and their representatives, where appropriate, had been involved. Some were seen to be out of date, and a small number had been carried on over a couple of years, but records did not show if they had been achieved. The action for this is made under outcome 1.

Staff spoken with were knowledgeable about the needs of the residents, and the plans were seen to inform the service delivered. For example behaviour support plans, likes and dislikes and occupational therapy assessments setting out moving and handling techniques.

Evidence was seen that staff were using social stories with residents in some cases, and this set out in picture format and plain English different scenarios and their outcomes. This was to support some residents in areas that were difficult for them. For example getting up in the morning and going out to their day activity.

For residents who were moving either within the service, or out of the service detailed transition plans setting out any actions needed ahead of the move, how the resident was to be supported during the move, and any ongoing help following the move. This had supported residents to move in a planned and organised way. It was noted that the admissions policy required further improvement around residents moving within the service, and this is explained under outcome 4.

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 found that several improvements had been made since the inspection in April 2015. These improvements related to the décor, state of repair and layout of the houses. However, some issues from the last inspection were still outstanding.

The centre was made up of four units: one bungalow that was under extensive renovation with residents temporarily living in another unit, a second bungalow accommodating seven residents, and 2 two-story houses which both housed two residents. Inspectors visited the three units that were occupied during the inspection.

All three units were clean, and were decorated in a comfortable and homely way. They were maintained to an acceptable standard with improvement work on-going. There was suitable levels of natural and artificial lighting, heating and ventilation. Each unit contained aids and appliances to promote accessibility for the residents, if their needs required it. Residents also had storage facilities for their possessions.

The bungalow inspected had two single bedrooms, one twin bedroom and one multi-occupancy bedroom. Three residents were staying in the multi-occupancy bedroom; as stated in the last inspection report and in outcome 1 this fails to promote privacy and dignity for the residents.

There was a multifunctional bathroom which contained a bath, shower and laundry facilities; it was found in the last inspection that this did not meet the residents’ needs. Toilets were located in a separate room. A communal living area was located in the centre of the house and a large kitchen and dining area was also observed. There was a smaller living room which was frequently used for receiving visitors.

Both of the two storey houses contained a kitchen and dining area, a living room, a bathroom and a staff office. One house contained two bedrooms, while the second contained three bedrooms. In these houses, each resident had their own bedroom which was decorated in a personalised way. One resident chose to show us their bedroom, and was very proud of this personal space.

One of these houses previously had a screen separating the kitchen and dining area. Since the last inspection this screen has been removed, allowing residents independent access to the whole kitchen and dining area. The front window frame of the house had also been repaired.

In the other two storey house, the food preparation equipment that was being used upstairs has been removed, and the house was no longer being utilised as two separate flats.

Improvements made since the last inspection included work taking place to renovate one of the bungalows to bring it in line with the environmental standards required by the regulations. Similar renovation was planned for the other bungalow. Decoration and repairs had also taken place.

Judgment:
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 unit, risk assessments on the environment and work place at unit level had not yet been carried out or any control measures put in place 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 units in the campus. These were seen by inspectors. Once the risk registers were developed for all units, 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.

It was noted that up to date and fully completed individual risk assessments were in place for each resident, and focused on their individual skills and needs. This had improved since the previous inspection.

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 centre, 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, cleaning of soiled clothing.

There was an organisation wide emergency plan and staff were familiar with them. Each resident had an individualised evacuation plan developed.

There were procedures in place on the management and prevention of fire. Fire procedures were prominently displayed in each unit. There was evidence of fire safety training provided to staff, however, around a quarter of staff had not completed up-to-date refresher training. All staff spoken with knew what to do in the event of a fire. The action for this is made under outcome 18.

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, some fire doors had been installed in two units in the centre. However, a number fire doors were still required to be installed in all four units. 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 - Moderate

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

**Findings:**
Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. However, the systems in place to investigate allegations of abuse and the policy on the prevention of abuse required review, as did the arrangements for use of restrictive practice.

There was a policy on safeguarding residents from abuse and it 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 roles of the person in charge were not clearly described. For example, who is responsible for notifying allegations of abuse and submitting follow up action to the Authority. A draft procedure was later shown to inspectors which was expected to clarify this. This is discussed in Outcome 18.

When inspectors met the person in charge at the centre during the previous inspection they were clear on their role when any allegations of abuse were reported. A nurse manager was covering the management of the centre on the first day of the inspection. She was also familiar with the types of abuse and the internal reporting arrangements in place. However, as outlined in the paragraph above, the agreed roles and responsibilities of managers were not so clear.

The provider had appointed a designated adult protection officer. The responsibilities for this person were contained in the policy, and the officer was a useful resource to staff should they need to discuss any concerns they had.

There was evidence since the last inspection that incidents of allegations of abuse were investigated and managed in accordance with the centre's policy. However, the timeliness of completing investigations required review, as there were gaps of a number of months between incidents occurring and investigations being completed. This was discussed with senior management during the inspection.

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, one third 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, although there were environmental limitations as set out in outcome 6. All residents had an intimate care plan in place, which guided care.

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.

Residents had communication passports which included the behaviour support plans for all residents with behaviour that challenges. There were systems in place to support residents with their responsive behaviours. There were positive support plans developed where required. The support plans were reviewed and guided staff practice on how to support the residents. However in two examples the support plans did not include that the residents had been prescribed medication that could be used as required when the support plan had not been effective. This presented a risk of staff not knowing about this approach, and so being equipped to meet the care support needs of the residents.

Where there were restrictive practices in use in the centre there were risk assessment completed, and protocols written clearly to support staff to understand when they could and could not be. All restrictive practice was reviewed at the rights committee on a regular basis.

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

Findings:
Inspectors found that residents’ needs were generally being met. However, improvement was needed to the systems in place, including documentation, to ensure that residents healthcare needs were regularly reviewed, treatment facilitated and care records updated if their needs changed.

While reviewing residents records and speaking with staff it was clear that where residents had healthcare needs they were identified, and appropriate action was taken. For example records showed if residents were expressing they were in pain, then it was recorded that they had seen the GP and received appropriate treatment. Where residents were not able to say they were in pain, inspectors saw there was guidance for staff about how residents may communicate pain in other ways. On the day of the inspection, staff were seen to be taking action where it was identified a resident was feeling unwell.
Some residents had long term health needs and records showed staff had created links with the health professionals both within the service, and external specialists. For example some residents had contact with consultants from local hospitals. The letters, healthcare instructions and notes recorded for residents showed residents were having appointments scheduled and feedback was being given following the meeting.

Records showed residents had access to a general practitioner (GP), including an out of hour’s service. Within the service there was an occupational therapist, physiotherapist, psychologist, social worker and psychiatrist. Residents were supported to access other professionals from the community such as chiropodists, opticians and ophthalmologists.

In each of the houses, residents had a range of healthcare needs, and systems, including completed documents, were in place to monitor their health specifically in relation to those needs. For example weight monitoring, records of seizures, and use of ‘as required’ medication, (PRN). There were also a number of protocols in place to describe how care was to be provided in certain cases, for example if a resident had an epileptic seizure and needed rescue medication.

There was a record of medical appointments for each resident, and also information about when next appointments were due, however this was not consistently completed which could be a risk for residents missing appointments.

Inspectors reviewed a selection of residents’ personal files and it was identified that all residents had ‘My health plan’ in place that gave an overview of their healthcare needs. However, for some it had been written in 2013, also it was not clear when additional information was added as it was not signed or dated. This meant that there was no comprehensive document that set out the residents current healthcare needs and it was not possible to see if needs were being reviewed and appropriate treatment provided. This action remains outstanding from the last inspection. The action for this is made under outcome 5.

Two examples were seen where it was not clear if advice given by the nutritionist was being followed, or needed to be reviewed, because guidance was either not dated, or there was no evidence of the guidance being followed.

Inspectors didn’t directly observe a mealtime during the inspection but did hear staff asking residents what they wanted to eat for breakfast, snacks and evening meals. Some residents were involved in cooking and choosing their menu, in other houses they were supported by the staff to make choices.

A range of food, snacks and drinks were seen to be available in each of the houses, and staff confirmed they shopped regularly and purchased food that reflected the tastes of the residents in the house. Some residents also enjoyed going out for meals.

**Judgment:**
Non Compliant - Moderate
**Outcome 12. Medication Management**  
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**  
Health and Development

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

**Findings:**  
Medication practices were sampled in a small number of units in the campus. The medication policy was reviewed and found to meet best practice requirements. There was a pharmacy technician on site to support staff and residents.

Inspectors reviewed a sample of prescription and administration records and saw that they complied with good practice, medication was individually prescribed and good practice was observed in providing residents alternative forms of medication where necessary.

Secure fridges were provided for medications that required specific temperature control.

There were appropriate procedures for the handling and disposal of unused and out-of-date medicines. Staff knew about the procedures for reporting medication errors.

There was evidence of medication audits taking place. It would improve practice if staff were aware of the findings and improvements required.

**Judgment:**  
Compliant

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

Feedback was provided to the management team on the deficits in this document. Improvement was required to this document, as stated in the last inspection report.

**Judgment:**
Non Compliant - Moderate

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**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
There was a person in charge nominated since the last inspection. The person in charge was suitably qualified, experienced and full time in her role. This was an improvement from the last inspection, and fully addressed the requirement of the regulations. An interview had been held with the person during the previous inspection in April 2015 in which she demonstrated knowledge of the Regulations and her responsibilities. The person in charge was not working on the first day of the inspection and in training the following day so contact was limited during this inspection.

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 others 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:
- examples were seen where residents files and information would guide staff in how to fully meet their needs
- examples were seen where health care 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,
- staff were not formally supervised,
- managers overseeing the centre were not fully supported in their role,
- there was no lines of authority clarified at unit level in the centre

Inspectors read reports of unannounced visits to one unit in the centre. There 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 to complete unannounced visits of all units in the centre 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

### Outcome 15: Absence of the person in charge

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

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The provider nominee was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days.

The provider nominee had appropriate contingency plans in place to manage any such absence. There were three nurse managers available to cover absences of the person in charge. These persons were all on leave during the inspection. A nurse manager was deputising in these persons absence during the inspection.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Since the previous inspection, staffing levels had improved. This was linked to residents planned moves out of the centre. These changes had improved the quality of life for some residents who now had more opportunities for regular social activities.

In two units, the bathroom facilities met the needs of the resident. One unit was being refurbished to improve the bathrooms and the remaining unit would be receiving a refurbishment following the completion other works.

Judgment:
Compliant

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):

Findings:
Inspectors found there were experienced staff to meet the assessed needs of the residents at the time of the inspection. However, improvements were required in relation to supervision of staff and staff training.
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.

There was a planned roster read by inspectors. However, the rosters available did not fully reflect who had actually worked on a shift. For example, inspectors met a member of staff in a unit and they were not on any of the rosters that were available. It was also noted the rosters did not include the full names of person, grade and if they were agency or relief staff. See outcome 18 for the action on this point. 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 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 human resources team showed inspectors training record of all staff training completed to date in the centre. The person in charge ensured all staff in the centre were provided with access to mandatory training including fire and protection of vulnerable adults. However, records read showed that out of 31 staff up 13 staff had not completed training in the prevention of abuse in over two years, and nine had not completed fire safety training in over one year. HR explained to inspectors the action that was taken to address the 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):

**Findings:**
Inspectors found 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.

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 available as required, however there was no infection control policy. The other policies were in place, but improvements were identified. The complaints policy did not reflect practice in the centre (see Outcome 1). The policy on the prevention of abuse did not fully guide practice (as outlined in Outcome 8). The risk management policy was not being fully implemented (outcome 7).

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

### Judgment:

Non Compliant - Moderate

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### 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:

Helen Lindsey  
Inspector of Social Services  
Regulation Directorate
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>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004925</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>10 and 11 November 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>21 December 2015</td>
</tr>
</tbody>
</table>

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 given opportunities, in line with their disability, to be involved in planning and decisions about their care and support.

1. Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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 PIC in conjunction with the management team will review the systems and practices in place for each house.
- The purpose of the review is to ensure all systems promote and maximise each person’s involvement in exercising choice in their daily life and promote personal independence.
- Resident house meetings will demonstrate consistent and wider consultation.
- These meetings will be documented and actioned.

**Proposed Timescale:** 03/02/2016  
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents privacy and dignity was being respected in relation to their living space and intimate and personal care.

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:**
- Renovation works planned for this centre will provide better facilities for ensuring privacy & dignity. Planned works involve single occupancy bedrooms and separate bathroom and toilet facilities.
- Each resident in this centre will have their personal and intimate care document reviewed to assess how their privacy can be improved whilst awaiting renovations.

**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:
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.

3. **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, manager/PIC and officer level.
• 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 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.

4. 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:
• The statement of purpose and admission policy will be updated to reflect the following requirements for admission or transfer:
  • 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.
  • There are no more admissions to this designated centre as part of the Strategic Plan to move from congregate settings.

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.
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.
- the additional fees which could be charged to the resident.

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 and will include:
• 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 and Residents or Representative

Proposed Timescale: 30/03/2016

Outcome 05: Social Care Needs
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In some cases it was not described what residents current social and healthcare needs were and how they would be met.

7. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the
assessed needs of each resident.

**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 health and social 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 Plan 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:**
Not all residents health, personal and social needs had been reviewed to reflect their changing needs.

8. **Action Required:**
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

**Please state the actions you have taken or are planning to take:**
Each person’s plan will be subject to a review on a regular basis to ensure assessments reflect changes in need and circumstance. This will be scheduled at 3 month intervals or more often if required.

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

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The design and layout of the centre did not meet the residents needs as there was not adequate baths, showers and toilets of a suitable standard to meet the needs of the residents. Some residents did not have adequate private accommodation.
9. **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:**
Renovations are currently taking place within the campus to address bathroom privacy issues and bedroom occupancy within these residential areas.
- The plan for the two bungalows 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.

**Proposed Timescale:** 01/04/2016

<table>
<thead>
<tr>
<th>Outcome 07: Health and Safety and Risk Management</th>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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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 environmental risks in each unit.

10. **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.

**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.

11. **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:**
There was no guidance around infection control, and procedures were not in line with standards for the prevention and control of healthcare associated infections.

12. **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.
- Infection prevention policy references standards for prevention and control of HCI’s policy HIQA 2009.
- 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 provided in the centre.

**13. 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:**  
Works in all four locations are scheduled with an estimated completion date for March 2016

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

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### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Not all restrictive procedures were applied in line with evidence based practice as some support plans did not include details of chemical restraint as interventions to be implemented.

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

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

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**Proposed Timescale:** 28/02/2016  
**Theme:** Safe Services
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The timeliness of completing investigations into allegations of abuse requires improvement.

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

**Please state the actions you have taken or are planning to take:**
- Improvements have now been made to our Transfers and Relocations Committee and a number of successful relocations have taken place and this has enabled several cases to be closed. The work of this committee is ongoing.
- Representations are being made to the HSE in specific cases.
- Housing applications are also being made and links are being made with housing authorities.
- In order to improve timeliness of investigations we now have trained an additional 13 managers as investigators who will be available to conduct investigations under Trust in Care.
- An administrative support person is being recruited for Safeguarding and this will help with the workload of case management (prevention of abuse procedure).

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

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all recommendations made for treatment were seen to be facilitated.

16. **Action Required:**
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

**Please state the actions you have taken or are planning to take:**
- The PIC/PPIM have reviewed follow up actions following allied healthcare appointments with keyworkers for all individuals to ensure all actions are facilitated and completed.
- New personal plan documentation will facilitate clearer systems of documenting actions and outcomes following appointments with health care
### 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 meet the requirements of the regulations as it was not specific and did not reflect the units in the centre.

17. **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:
- The care needs of this centre and how these are being met
- Floor plans will be amended so size is visible (however there presently is a descriptive on each of the rooms in relation to size in the statement of purpose).
- A review will also ensure all items in schedule 1 are identified.

### 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.

18. **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 review by senior management 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.
- 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.

**Proposed Timescale:** 01/04/2016  
**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.

19. **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:**  
- Unannounced 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 representative 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.

20. **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 17: Workforce

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roster in place did not reflect the planned or actual staff on duty.

**21. Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
- The Roster will be completed every 2 weeks. The roster will include all the staff names, staff grade and hours worked.
- It will identify the PIC who is on duty at that time.

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

**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.

**22. 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:** 21/12/2015  
**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.

**23. 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 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 completed supervision with the PPIM’s on a monthly basis.

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

**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 complaints, risk management and prevention of abuse policies required review as there were not being fully implemented in practice. There was no infection control policy.

**24. 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.
- Complaint Policy has been reviewed and updated and is out for consultation  
- Risk Management policy review has commenced  
- An implementation plan will be attached to each policy to ensure appropriate briefings regarding procedures and practice and responsibilities.
**Proposed Timescale:** 30/01/2016  
**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.

25. **Action Required:**
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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 Roster will be completed every 2 weeks. The roster will include name, staff grade and hours worked.

**Proposed Timescale:** 04/01/2016