

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Centre 5 - Cheeverstown Community Services (Hillcrest/Ballyroan)
Centre ID:	OSV-0003556
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Limited
Provider Nominee:	Paula O'Reilly
Lead inspector:	Karina O'Sullivan
Support inspector(s):	Michael Keating
Type of inspection	Unannounced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was unannounced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 14 September 2016 08:30 To: 14 September 2016 18:30

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

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

Summary of findings from this inspection

Background to the inspection:

An initial inspection in 2014, was completed as a result of the provider submitting an application to register this designated centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, at that time the centre was not found to be in sufficient compliance with the regulations in order for the Chief Inspector to grant registration. Following this, meetings were held between the provider and HIQA and subsequent action plans were agreed. An unannounced inspection took place in November 2015, improvements were identified; however, a number of issues remained. Poor managerial oversight and governance arrangements continued to be impacting upon the quality of lives of residents. The complex governance and management arrangements did not identify lines of authority and accountability. Subsequently in early 2016 HIQA issued the provider a timeline to implement

appropriate arrangements in relation to assigning appropriate persons in charge.

The provider put persons in charge in each designated centre. The person in charge of this centre was subsequently interviewed in June 2016. This inspection was primarily to ensure the revised governance arrangements were having a positive outcome for residents and to ensure agreed actions were being implemented. During this inspection inspectors found improvements; however, some actions submitted to HIQA remained outstanding. These are identified within the main body of this report.

How we gathered our evidence:

As part of the inspection inspectors visited the three houses within the designated centre, met with nine residents, and six staff members. Inspectors viewed documentation such as, care plans, person-centred support plans, recording logs, policies and procedures.

Description of the service:

This designated centre consisted of three houses, one house was based in Dublin 16 and the other two houses were located next door to each other in Dublin 6W operated by Cheeverstown House Residential Services. The provider had produced a document titled the statement of purpose, as required by regulation, this described the service provided. The designated centre aimed to provide community residential support to male and female adults with intellectual disabilities. There was local access to public transport. One resident informed inspectors "I am very happy living here, I can do my own thing and staff are also here to help me" another resident stated "I feel safe here and if I didn't I would tell staff".

Overall judgment of findings:

Fifteen outcomes were inspected against. Four outcomes were found to be in full compliance. Four outcomes were found to be substantially compliant and seven outcomes were found to be moderately non-compliant. Areas of improvement included health and safety in relation to the risk management, the information contained within both healthcare and personal plans and also the management of medication.

Three staff members facilitated the inspection as the person in charge was not on available on the day of inspection.

All proposals outlined and plans agreed will be verified at the next inspection.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.

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):

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

Findings:

Inspectors reviewed this outcome in respect of the actions identified in the previous inspection. Inspectors found the actions were achieved. However, the inspectors identified improvements were required in relation to the complaints policy.

Inspectors found there was a complaints policy and procedure in place, however, the complaints procedure did not specify a nominated person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure all complaints were appropriately responded to and a record of all complaints maintained

Residents had access to and were made aware of both the national and internal advocacy services.

Inspectors found accessible versions of the complaints procedure available and on display within the designated centre.

Judgment:

Substantially Compliant

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.

<p>Theme: Individualised Supports and Care</p>
<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: Inspectors reviewed this outcome in respect of the action identified in the previous inspection. Inspectors found the action was achieved.</p> <p>Inspectors found residents communication needs were now clearly outlined within residents' files. Throughout the inspection inspectors observed staff communicating with residents in their own preferred manner, as outlined within their communication passports.</p>
<p>Judgment: Compliant</p>

<p>Outcome 03: Family and personal relationships and links with the community <i>Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.</i></p>
<p>Theme: Individualised Supports and Care</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Inspectors found family, personal relationships and links with the community were being actively supported and encouraged. There was also a policy in place, this outlined visitors were welcome in the designated centre.</p> <p>Inspector found the staff team had gone to significant efforts to ensure contact with family members was maintained. Inspectors viewed evidence of this within several residents' files. Residents were being supported to keep in regular contact with family members. Staff members also accompanied residents on visits to family homes and family members and friends could visit the designated centre without any restrictions.</p>
<p>Judgment: Compliant</p>

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):

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

Findings:

Inspectors reviewed this outcome in respect of the action identified in the previous inspection. Inspectors found the action was achieved.

Residents now had written agreements in place.

Judgment:

Compliant

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:

An updated action plan was submitted by the provider at the request of HIQA this outlined progress in relation actions required. However, of the two actions detailed, one of these remained outstanding in relation to ensuring residents had up-to-date personal plans in place.

The organization had deployed a service improvement team to provide guidance on personal plans. This new system of social care planning was implemented throughout this designated centre. Inspectors did acknowledge improvement within many of the

care plans reviewed. However, some residents did not have their personal plans updated to reflect their current assessed needs.

Within other plans inspectors found no current active goals identified for one resident and within another plan reviewed in 2016 no goals present except the goals set in 2015.

Inspectors found some resident's social care needs were identified and residents had the opportunity to participate in meaningful activities appropriate to their interests and preference. These included areas such as, attending music events, social groups, sporting events and meeting friends and shopping.

Residents' family members were consulted in relation to the personal plans in line with residents and family members' preferences. There was evidence of this maintained within the resident's 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:

Inspectors reviewed this outcome in respect of the actions identified in the previous inspection. Inspectors found one of the actions remained outstanding, which related to premises issues in one of the houses comprising the designated centre.

Inspectors found the floor covering in the kitchen area of one house had been replaced. The provider outlined plans in place to transition residents from one of the houses to alternative accommodation. This was determined for various reasons, including issues with the premises, as the house was no longer meeting the needs of residents. The residents in this home also discussed their involvement in these plans including visiting potential homes. These plans were in advanced stages therefore, once accommodation is obtained, this will resolve this issue for the residents within this house.

Judgment:

Substantially Compliant

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 the designated centre was suitable and safe for the number and needs of residents. Inspectors found significant improvements were required in the area of safety plans, sharps management and risk assessments.

There was certification and documentation to show the fire alarms, emergency lighting and fire equipment were serviced by an external company as required by regulations. Inspectors found fire containment in relation to one house was not adequate as fire doors were not in place. However, there was a plan in place to move residents from this house to a more suitable premises.

Fire drills had taken place and documents recorded the time taken to evacuate. Any issues were identified along with the identification of residents, who had participated in the drill within the designated centre. The inspector viewed a drill dated 27 July 2016.

Inspectors found the sharps container was unlabelled and untagged. No guidance was available for staff within the designated centre in relation to the safe disposal of this container.

The designated centre had an organizational risk management policy in place this included, the specific risks identified in regulation 26. The designated centre had a risk register and this recorded a number of risks within the houses and the controls in place to address these. On the day of inspection inspectors found improvements were required in this area. For example, the use of shapes within one house was not identified within the risk register nor was the risk register dated or signed by a member of staff.

There were individual risk assessments for residents in place these included displays of behaviours, unexplained absence and trips and falls. Inspectors found this system required improvement as information contained in some individual risk assessments was different within some individual plans. In some instances inspectors viewed two risk assessments for the same area however, one was the updated version. Inspectors found this practice could potentially mislead staff members.

The designated centre had a health and safety statement dated 21 August 2007 displayed within one house and also a more up-to-date version dated 25 July 2016 was present. This outlined the responsibilities of the various post-holders within the organization. The statement referenced a wide range of policies and procedures that supported the statement and guided staff in their work practices. The designated centre had an emergency evacuation plan in place for a number of various events such as, fire, adverse weather conditions, flooding and power failure. The plan identified specific alternative accommodation to be provided in the event residents could not return to the designated centre. The HSE (Health Service Executive) guidelines for lone working dated September 2014 was present within the houses however, this was not implemented. There were no specific guidelines to guide staff in the area of lone working within the designated centre.

There was a system in place for recording accidents and incidents occurring in the designated centre. Staff outlined the process for dealing with these and ensuring learning from any adverse incidents or accidents occurred.

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):

No actions were required from the previous inspection.

Findings:

Inspectors found appropriate measures to protect residents from being harmed were in place within the designated centre. Improvements were required in relation to behavioural support plans.

The following areas were identified:

One file viewed identified the behaviour support plan was transferred into a person-centred plan in May 2014. Inspectors asked to view this plan; however, there was no identification of behaviour support within the person-centred plan. Staff also informed inspectors this information was contained within the communication passport however, this was unavailable. Therefore, inspectors found the behaviour support plans were not

kept under review and did not guide staff effectively and consistently in both verbal de-escalation and the use of chemical restraint. Relief staff members spoken with were unsure where this information should be located within residents' files.

There was a policy in place on the prevention, detection and response to abuse this was dated August 2014.

There were plans in place for providing intimate care to residents whom required support in this area. However, some of the plans viewed were undated and blank in some areas therefore, inspectors found it difficult to establish how current this information was.

Staff members had received training in the area of prevention, detection and response to abuse.

Inspectors found residents were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

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 each resident was supported to achieve the best possible health. Improvements were required within the details within the interventions specified for some healthcare needs and also the review of the effectiveness of the interventions.

The healthcare needs of residents were completed via a plan incorporating nine areas of assessments. These included areas such as, communication, breathing and circulation, nutrition and hydration, continence and elimination, personal care, meaningful activities and sleep and rest. This was a new system implemented since the previous inspection.

Inspectors viewed these healthcare plans and found some of these required improvement in the area of review and implementation of the interventions identified. For example, three monthly dietician reviews was identified as an intervention however, no evidence of three monthly dietician reviews were present. Staff members also

confirmed three monthly reviews did not take place.

Inspectors found some pressure sore assessments were blank and some were completed. However, no interventions were specified when some resident's were assessed as an at risk score from the assessment completed.

Another plan viewed in relation to weight reduction interventions did not specify, staff were to assist the resident to be weighed. However, inspectors viewed evidence of weight being obtained. Inspectors found the interventions identified for this aspect of care provision did not guide staff consistently.

Inspectors viewed duplication of information in some files for example, diabetic management plans were present in multiple formats, inspectors found this could mislead staff particularly when the designated centre was reliant on the use of relief staff members.

Inspectors found the number of goals and interventions set were excessive in relation to the resources within the designated centre. For example, six goals and forty six interventions were specified within one care plan. Inspectors were unable to see if these were achievable as interventions were required to be reviewed on a three monthly bases however, inspectors found no reviews had taken place.

Residents had access to allied healthcare professionals, inspector viewed evidence of this including physiotherapy and dentist.

Residents had access to a general practitioner (GP). Inspectors also viewed evidence of staff supporting one resident to move from one acute hospital to another acute hospital to receive outpatient care for a specific condition. The resident also discussed this with inspectors and identified this was their choice and staff facilitated this change with them. Other residents were able to discuss aspects of their care plan in relation to epilepsy management and other medical conditions. Inspectors viewed phlebotomy results as required for some residents due to their diagnosis or their medication prescribed.

Residents requiring modification to the texture of their food was clearly outlined in the residents file. Staff members were knowledgeable in relation to the implementation of resident's food requirements. Inspectors viewed feeding, eating, drinking and swallowing (F.E.D.S) assessments in place for some residents.

Regarding food and nutrition inspectors found residents participating in mealtimes within the designated centre in accordance with residents' preferences in relation to food choices. Residents participated in cooking in accordance with their own preferences.

Inspectors viewed user-friendly menu selection of refreshments and snacks were available for residents outside mealtimes within the designated centre.

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):

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

Findings:

Inspectors found the oversight of the medication management system within the designated centre required improvement.

Non-compliance identified with regulations included:

- Accurate stock balances were not maintained for some medications. For example, loose medication and also for medications within individual dispensed containers were found to be inaccurate.
- The opening dates were not recorded for some medications for example, creams.
- No guidance was available for some p.r.n (a medicine only taken as the need arises) medication in relation to residents prescribed two medications for the same symptoms. No guidance was available to staff when one medication could be administer instead of the other or if both medications should be administered. Staff members were unable to identify to inspectors when these medications would be administered and why.
- Some administration recording sheets did not match the administration record for example, antibiotic medications.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received.

Inspectors observed all medication was stored in a secure, locked cabinet in a locked area. The keys to access the medication cabinet were held securely by staff.

There was a system in place for recording, reporting errors and reviewing medication and inspectors viewed examples of these.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Inspectors found the statement of purpose meet the requirement of the regulations as outlined in schedule 1. However, Appendix 1 of the document required updating.

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):

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

Findings:

Inspector found the three actions from the previous inspections were achieved. Inspectors did identify some improvements in the governance and management of the designated centre. This included the appointment of a person in charge and an on call system available to staff members. This information was clearly available with contact numbers for all members of staff present. However, improvements were required in the area of accountability, the completion of audits and reviewing staff performance.

Inspectors observed very limited auditing of areas within the designated centre. Staff members spoken with were unable to identify areas except for medication and a care plan audit conducted by staff outside the designated centre. Inspectors went through some audits of care plans and found actions from the previous review in August 2016 remained outstanding.

Inspectors viewed minutes of staff meetings within the designated centre. There were standard agenda items, including review of medication errors and complaints. However, this was inconsistent among some houses and between some meetings. Within other meetings clear communication was evident in relation to feedback from the providers visit discussed with the team, on 24 April 2016 and a medication audit was discussed on 23 June 2016.

A sample of staff performance reviews were viewed during the inspection, inspectors found the system required improvement. For example, out of three records viewed none were completed in 2016. One was completed on 8 February 2015 another one was completed on 17 March 2010 and the third was completed on 29 June 2015.

Inspectors found there was a clearly defined management structure with lines of authority in place. However, the lines of accountability were unclear among the layers of management within the designated centre. Inspectors found several incidences of this during the inspection when clarity was sought in relation the areas concerning the designated centre or individual residents. Various other departments or professionals were identified as accountable for these areas including social workers and day service departments.

Inspectors found an annual review of the quality and care completed in this designated centre for 2015.

The provider had carried out an unannounced visit on a six monthly basis. This reviewed the safety and quality of care and support provided in the designated centre. Inspectors viewed the previous one completed in each of the three houses individually.

Judgment:

Non Compliant - Moderate

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:

Inspectors reviewed this outcome in respect of the action identified in the previous inspection. Inspectors found the action was achieved.

Inspectors found the designated centre was resourced to ensure the effective delivery of care and support in accordance with the designated centres statement of purpose.

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):

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

Findings:

Inspectors found the designated centre did not have sufficient staff numbers with the right skill mix, qualifications and experience to meet the assessed needs of the residents. Inspectors found improvements were required in relation to the provision of consistent staff members and staff supervision.

Inspector viewed the proposed and actual staff rota and found them to be accurately maintained. Each of the houses were reliant on relief staff members however, inspectors did acknowledge the reliance upon relief staff and numbers used had reduced since the previous inspection.

The inspectors found the three houses within the designated centre were in effect operating as standalone centres instead of one designated centre. For example, supports and resources were not considered or shared between houses which happened to be next door. Inspectors found documentation in relation to risk management and lone working did not support relief staff members to meet the assessed needs of residents. These documents were not reflective of current practice within the designated centre.

Inspectors found staff received appropriate training within the sample of training records viewed.

Staff files were not reviewed as part of this inspection as these are held within an office off site these were reviewed as part of the previous inspection.

Inspectors viewed staff performance development reviews however, some of these were not maintained up-to-date.

These were no volunteers within the designated centre.

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 respect of the action identified from the previous inspection. Inspectors found the action was ongoing in relation to implementing and reviewing schedule 5 policies. Including:

- provision of behavioural was in draft format
- the use of restrictive procedures and physical, chemical and environmental restraint was in draft format
- recruitment, selection and Garda vetting of staff was dated 2004
- staff training and development was dated 2009
- no policy in relation to the monitoring and documentation of nutritional intake.

Over the course of the inspection inspectors found the retrieval of schedule 3 documents difficult. Some documents were present in duplicate versions for example, healthcare plans and individual risk assessments. Other aspects of residents' assessments were left blank and undated. Inspectors found these documents did not guide staff effectively in the areas of care delivery.

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:

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Centre 5 - Cheeverstown Community Services (Hillcrest/Ballyroan)
Centre ID:	OSV-0003556
Date of Inspection:	14 September 2016
Date of response:	08 November 2016

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:

It was unclear within the complaints policy who was the nominated person other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained independent of the person nominated to deal with complaints was within

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

the organization.

1. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

Safe guarding administration staff will audit all complaints to ensure that they are appropriately responded to in a timely manner, all records are maintained and the complainant is satisfied with the process.

Proposed Timescale: 31/12/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Some residents did not have a comprehensive assessment reflective of changes in need and circumstances completed at least on an annual basis.

2. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

PICs to coordinate with POMs Coordinators and house staff to ensure the personal plan is current updated and capture the health care, personal and social needs of the residents. Also evidence in the week to view that the resident's personal plan under their health care and social care needs are being worked on and the evidence documented to capture same.

Proposed Timescale: 01/03/2017

Theme: Effective Services

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

Some personal plan reviews did not assess the effectiveness of the plan in place for residents.

3. 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:

PICs to coordinate with POMs Coordinators the auditing of assessment process (folders) to capture health care, personal and social needs of each resident. The PIC will feed back this information through team meetings in each house and will ensure any follow up actions are completed.

Personal Files will be updated by the house staff to ensure that those health interventions and social goals in place are being implemented and achieved.

Proposed Timescale: 28/02/2017

Theme: Effective Services

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

Reviews of some resident's personal plans did not result in residents goals being updated.

4. 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:

The staff with the resident and other team members will review the current personal plan for 2015 and close off on any outstanding outcomes. The staff in each house will then set new outcomes with residents for 2016/2017 and the progress of these outcomes will be audited by the PIC in conjunction with the POM's coordinators and feed back to staff through mentoring, supervision and staff meetings.

Proposed Timescale: 31/12/2016

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 was insufficient facilities within one house to meet the residents' needs.

5. 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:

Staff team with PIC and SSDL coordinator to manage the transition of the residents from their current home to their new home. This transitioning has commenced and the residents have looked at their potential new home and feel positive about a move in partnership with the housing association. Transition plans will be developed by the pic and their team once the house is closer to signing.

Proposed Timescale: 15/03/2017

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:

Systems in place in the designated centre for the assessment, management and ongoing review of risk, required improvement in relation to the location risk register and individual risk assessments.

Staff members working in a lone working capacity were not effectively guided by policies or documentations.

6. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

Risk assessments relating to behaviour, unexplained absence and trips and falls will be audited against the individual plans to ensure the information is consistent. This will be completed in collaboration with the PIC and house staff.

The Lone Worker Policy was circulated in draft for comment by the quality manager on the 24th of November. The PIC in collaboration with the Community manager and staff will develop a local procedure which will ensure the policy is operational in this designated centre.

Proposed Timescale: 01/01/2017

Theme: Effective Services

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

Adequate arrangements for the management of sharps and disposal of sharps were not in place within the designated centre.

7. 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:

PIC drafting a sharps policy statement and stickers for sharps boxes presently in progress.

Risk assessment on sharps boxes to be included in risk register summary under the heading Health and safety to be amended by ADOS.

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

Adequate arrangements for containing fires were not evident within one house.

8. 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:

Health and Safety manager to order installation of fire door for kitchen to ensure fire containment in the stair well.

Proposed Timescale: 01/12/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Some staff did not have up-to-date knowledge and skills, appropriate to their role, to respond to displays of behaviour and to support residents to manage their behaviour. This was evident when inspectors requested to view behavioural supports plans and staff members were unable to locate these within the designated centre.

9. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

PIC to review staff training in relation to positive supports and mentor and support staff to gain a great understanding of positive support plans. PIC to review the allocation of staff in each house and match the skills to the positive supports needed to support the resident.

Proposed Timescale: 25/11/2016

Theme: Safe Services

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

Guidance for staff providing intimate care to some residents were not provided with sufficient details. Some aspects of these plans were blank and others did not contain a date of completion.

10. Action Required:

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

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

PIC with support from POM coordinators to mentor, monitor and review intimate personal care practices including the written plan to ensure personal intimate care is completed with dignity and respect and the plan guides practice and the residents preference.

Proposed Timescale: 25/11/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Inspectors were unable to determine if appropriate healthcare was provided in accordance to some residents plans as the effectiveness of the interventions specified was not monitored.

Healthcare interventions were not evident as a result of some assessments such as, pressure sore assessments.

11. Action Required:

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

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

POMs Co coordinators to audit folders with staff and include only relevant assessments.

Any assessments for individuals that are not needed will be removed from the plan.
POMs coordinator will report back actions to PIC who will ensure follow through by Mid November.

Proposed Timescale: 15/11/2016

Theme: Health and Development

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

Follow up required by some residents was not evident within the designated centre for example, dietician reviews.

12. 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:

POMs Co coordinators to audit healthcare plans with staff to ensure care plan captures the resident's priority health needs and ensure interventions are appropriate and achievable. The health assessments specifically requiring review in this designated centre relates to Pressure Sores, Weight Loss, Dietetic reviews and follows through on same.

Proposed Timescale: 30/11/2016

Outcome 12. Medication Management

Theme: Health and Development

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

The opening dates were not recorded for some medications for example, creams.

No guidance was available for some p.r.n (a medicine only taken as the need arises) medication.

Some administration recording sheets did not match the administration record for example, antibiotic medications.

Accurate stock balances were not maintained for some medications.

13. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

PIC is liaising with Community Pharmacy and the following issues are being addressed: New printed Kardex is being implemented with Audit Return sheets for recording within this DC.

An additional column has been added into the PRN kardex to indicate the preference for multiple drugs. This will allow staff to know which medication to use first.

Missing labels will be reprinted for those without.

Proposed Timescale: 30/11/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

Appendix one of the document required updating.

14. 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:

CNM3 will meet with Senior Manager to update this section of the statement of purpose.

Proposed Timescale: 30/11/2016

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:

Clear defined lines of accountability among the layers of management were not evident within the designated centre.

15. Action Required:

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

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

The completion of role and function of the PIC will provide clarity regarding the overall responsibility to follow through and close off actions relating to the residents in this designated centre. Key areas identified in this inspection related to follow through on audits, MDT input and staff performance reviews and supervision.

Proposed Timescale: 08/11/2016

Theme: Leadership, Governance and Management

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

Records made available to inspectors in relation to staff's performance management did not demonstrate effective arrangement in place to develop and performance manage staff members.

16. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

All staff has had a performance Management review in 2016. Two staff reviewed under inspection had just returned from leave. PIC performance review dated 2010 was conducted in Beeches. PICs reviews are held in a separate folder in Community office. The two staff are now scheduled for review.

Proposed Timescale: 20/11/2016

Theme: Leadership, Governance and Management

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

Lack off follow up on audits completed to ensure the service provided was safe, appropriate to residents' needs and consistently and effectively monitored.

17. 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 PIC will establish a clear system identifying those audits to be completed, by whom and the learning and actions taken. PIC is responsible and will ensure staff are familiar with its contents and actions required by mid November.

Proposed Timescale: 15/11/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The designated centre was reliant on relief staff in order to function however, there was insufficient support provided to these members of staff in relation to the assessed needs of residents for example, in relation to displays of behaviours.

18. 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:

Staffing resources across the designated centre are under review and the following actions are being taken:

- 20 hr contracted staff has been taken on to work within DC5 and 6 to address staffing shortfall.
- Start times for relief staff will be earlier to allow time to review personal Files and needs of the residents.
- Regularly updated Communication passport in each house to familiarise relief staff with peoples support needs.
- CNM3 who has overall oversight will review staffing resources with the PIC in this designated centre and establish the relief bank of staff for this centre to allow for greater regularity and consistency to be provided.

Proposed Timescale: 01/01/2017

Theme: Responsive Workforce

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

Inspectors found the system for supporting and supervising staff and relief staff members required improvement.

19. 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:

- PICs to visit the houses weekly.
- Support will be formalised across the houses.
- Phone and or direct contact has been established with all houses each evening
- Plan to ensure staff meetings across the whole designated centre on a quarterly basis.

Proposed Timescale: 30/01/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

All of the policies and procedures set out in Schedule 5 were not available within the designated centre for example, no policy in relation to the monitoring and documentation of nutritional intake.

Some policies were in draft format such as, provision of behavioural support policies and the use of restrictive procedures and physical, chemical and environmental restraint was in draft format.

20. 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:

All policies and procedures as set out in Schedule 5 of the Health Act 2007 have been compiled in a folder and formatted for this designated centre.

All policies as set out in Schedule 5 have been made available electronically on an organisation wide shared folder and all staff will be made aware of how to access this folder during a policy information day scheduled to take place in November 2016

Proposed Timescale: 30/11/2016

Theme: Use of Information

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

Some policies and procedures were not reviewed at intervals not exceeding 3 years for

example, recruitment, selection and Garda vetting of staff policy was dated 2004 and staff training and development policy was dated 2009.

21. 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:

A schedule of reviews for all policies has been set out and implementation plans have been updated and included in the Schedule 5 policy folder where applicable. All policies will be reviewed at intervals not exceeding 3 years.

The HR policies will be reviewed before the end of 2016.

Proposed Timescale: 01/01/2017

Theme: Use of Information

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

Some of the schedule 3 documents were present in duplicate versions for example, healthcare plans and individual risk assessments and other aspects of residents assessments were left blank and undated.

22. Action Required:

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

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

An audit will be completed by staff for each of the resident's personal files under the supervision of the PIC. This audit will be done against the records identified in the schedule 3.

Proposed Timescale: 01/02/2017