Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Centre 1 - Cheeverstown House Residential Services (Younger Persons)
Centre ID:	OSV-0004924
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):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	5

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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
20 June 2017 08:30	20 June 2017 20:15

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
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 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This was HIQA's (health information and quality authority) fourth inspection of this designated centre. 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 the time the designated 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, and improvements were identified, however, a number of issues remained outstanding. Poor managerial oversight and governance arrangements continued to be impacting upon the quality of lives for 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 designated centre was subsequently interviewed in June 2016. This was followed by another inspection October 2016 resulting in the centre gaining registration with an additional condition attached to the registration of the centre. Condition8 outlined that the provider shall implement and adhere to the action plan submitted in response to the inspection carried out in October 2016.The previous failings were followed up during this in this inspection. Overall inspectors identified improvements had occurred, however, some actions submitted to HIQA remained outstanding. These are identified within the main body of this report.

How we gathered our evidence
Over the course of this inspection, inspectors met with thirteen residents, residents communicated in their own preferred manner with inspectors. Residents allowed Inspectors to observe their daily life in the designated centre. Inspectors met with the manager of the centre on the day of inspection and staff team and reviewed various sources of documentation which included the statement of purpose and residents' files. Inspectors also completed a walkthrough of the centre's premises and visited the four houses within the designated centre.

Description of the service
This designated centre consisted of four houses, one house was based in the community in Dublin 24 and the other three units where located in Dublin 6W in a campus setting operated by Cheeverstown House Residential Services. This designated centre was home to 14 residents over 18 years of age and provided respite care for up to 6 residents including children on alternative weeks. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The designated centre aimed to provide residential and respite support to male and female adults with intellectual disabilities.

Overall judgment of our findings
Of the 10 outcomes inspected against one outcome was found to be in full compliance. Four outcomes were found to be substantially compliant and five outcomes were found to be moderately non-compliant. Areas of improvement included staffing, medication management and information contained within both healthcare and personal plans.

Staff members facilitated the inspection together with a manager and a clinical nurse manager 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):
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 two of the three actions had been achieved.

Inspectors reviewed the complaints log and found that complaint's were addressed and followed up as appropriate. There was a complaints policy in place and inspectors found the issues identified from the last inspection had been addressed.

Inspectors reviewed a sample of residents' finances and found evidence of residents paying for scans and procedures from their own personal funds, with no evidence of consultation with family members. This was also identified in the previous inspection.

No other aspect of this outcome was reviewed as part of this inspection.

Judgment:
Substantially 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:
Overall, inspectors identified that some progress was evident within residents personal plans. One of the two actions from the previous inspection had been achieved; however, improvements were required to ensure residents' goals were reviewed to assess the effectiveness of residents personal plans.

Inspectors viewed a sample of six personal plans; these had been updated to reflect residents current assessed needs. Some personal plans clearly outlined person-centred goals such as, visits to a grave, to make a memory box and attend concerts. However, inspectors identified some goals set were not reviewed to assess the effectiveness of each individual plan. For example, within one plan a goal for a resident to have access to a sensory garden in 2013 was identified. Later in the document it stated the resident showed no interest in sensory items, this was dated 11 April 2017. The resident's achievements were listed for 2013. Even though there were goals set there was no identification of any other achievements since 2013. Two other plans viewed identified that residents wished to gain independent living skills and to develop a role within the community, however, no evidence of review or progress was evident in relation to this aspect of care provision.

Some residents attended a day service outside of the centre and other residents received a day service within the centre. Inspectors viewed evidence where one resident was not in receipt of any day service and this was identified within the personal plan as a goal. Inspectors requested an update on this, however, staff members identified they were informed to remove this as a goal as this was currently being dealt with as a compliant. Inspectors found this response did not address the need of the resident from a social perspective. Inspectors observed some residents in two units were not engaged in meaningful activities. As some residents were seated in chairs in the units with no apparent stimulation for significant periods of time.

Inspectors viewed evidence where residents' family members were consulted in relation to the personal plans in line with residents and family members' preferences. One inspector spoke with a family member during the inspection. They identified they were happy with the service provided and felt consulted in relation to the care provided to their family member.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
Overall, there were systems in place to promote the health and safety of residents, visitors and staff. Areas identified in the previous inspection had been achieved, however, during this inspection other areas were identified in relation to infection control measures.

The centre had infection prevention, and control procedures in place. Inspectors observed personal protective equipment and hand hygiene facilities were available in the centre. There were appropriate clinical waste systems in place in the centre. However, improvements were required in the use of equipment as some equipment labelled as single use items by the manufactures were used multiple times over a number of days. Inspectors also noted the management of an infectious disease was not clearly outlined in relation to the procedures regarding wound sites.

The centre had an up-to-date health and safety statement in place. This outlined the responsibilities of the various staff members within the organisation.

The centre had a policy on the management of risk. The centre maintained a risk register which outlined risks in the centre and the controls in place to manage the risk. Risks included medication, falls, fire and chemicals. There were individual risk assessments for residents in place these included epilepsy, absconding and behaviour.

There were systems in place for the prevention and management of fires. 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. The procedures to be followed in the event of fire were displayed in a prominent place. Regular fire drills were taking place in the centre and recent fire drills identified issues with evacuating all residents. The centre was in the process of addressing issues identified. Staff spoken with were able to tell inspectors what to do in the event of a fire.

Judgment:
Substantially Compliant

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

Findings:
There were appropriate measures in place to protect residents from being harmed and to keep people safe. Two of the three actions form the previous inspection had been achieved, additional areas in relation to restrictive practice were also identified during this inspection.

Inspectors viewed two behaviour support plans, these clearly outlined the different stages of escalation and both reactive and proactive strategies staff members were to engage in with residents. However, inspectors found the documents did not guide staff members effectively in the administration of PRN (a medicine only taken as the need arises) medicine. Prior to administrating any PRN medicine to alter a resident's behaviour, pain relief was administered first. From speaking with different staff members different approaches were used in relation to this. One staff member identified if the pain relief did not take effect after 30 minutes they would proceed to administer the PRN medication prescribed to alter the resident's behaviour. Another staff member identified they would wait for 60 minutes before proceeding to administer a second PRN. Inspectors identified this level of inconsistency could result in a resident not receiving appropriate treatment to respond to their needs. Inspectors viewed one incident when a resident was administered a PRN medication for pain at 19:30hrs, another PRN medication for pain relief was administered at 23:00hrs and at 00:30hrs a PRN to alter the resident's behaviour. The daily notes viewed outlined the resident continued to engage in displays of behaviour during this period.

Inspectors also identified another resident was prescribed night sedation, however, guidelines were not present to guide staff in relation to the appropriate administration. For instance, staff maintained a 24 hour sleep chart, inspectors viewed this document and found the resident had slept for 6 hours during the day and was administered night sedation that night. Another night the recording chart indicated the resident did not sleep, yet no medication was administered. Inspectors identified staff members were not guided effectively to analyse other underlying factors why the resident may not be asleep by 23:00hrs.

Inspectors viewed a monitor in place within one resident's bedroom. Inspectors requested evidence if this product was prescribed for the resident from a medical

perspective, however, this was not available. In the absence of the devise being prescribed for the resident, this intervention should be notified to HIQA as a restriction in accordance with the organisations and HIQA guidance documents. Staff members present were not aware of the rationale behind the devise as this was in place for a number of years.

Two staff members required training in the management of behaviour that is challenging including de-escalation and intervention techniques. Five staff members required refresher training in the area.

Inspectors found intimate care support plans were in place for various aspects of intimate care provision for residents requiring them, this had been achieved since the previous inspection.

Inspector spoke with members of staff and one staff member was unclear in relation to what was the procedure should an allegation of abuse arise within the designated centre. Inspectors viewed the training records for 40 members of staff and all staff members had received training the area of adult protection and safeguarding training. One staff member required refresher training in the area.

Judgment:
Non Compliant - Moderate

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 identified improvements had occurred in relation to meeting residents' healthcare needs. One of the two actions had been achieved from the previous inspection, however, further improvements were required in relation to the details contained within resident's healthcare plans.

The healthcare needs of residents' were completed via a plan incorporating nine areas of assessments. These included, communication, breathing and circulation, nutrition and hydration, continence and elimination, personal care, meaningful activities and sleep and rest. Inspectors viewed six healthcare plans and found some of these required improvement in the following areas:

- the details contained within some of the plans required improvement for example, ensure adequate hydration. Another plan viewed stated to maintain a resident's weight, however, the resident's weight was not specified. Inspectors identified staff members were not guided effectively to ensure some residents received the required healthcare provision

- the review process in place for areas identified required improvement to identify the effectiveness of the interventions implemented to ensure these were having a positive impact on resident's healthcare needs.

Inspectors viewed some epilepsy plans in place and these guided staff members in effective delivery of care in relation to seizure management.

Advanced care directives were in place for two residents, one had recently been reviewed by a multidisciplinary team including resident's family members. This had resulted in additional treatment regimes being included within the plan due to changes in the resident's healthcare. The second resident was currently under review in relation to what measures and treatment regimes were to remain within the directive.

Residents had access to a G.P. (general practitioner), speech and language therapist, physiotherapy and clinical nurse specialists.

Any resident requiring modification to the texture of their food had this information outlined in the residents' files. The inspector 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.

Judgment:
Substantially Compliant

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 identified progress had been made in relation to the medication management

system within the centre as one of the two actions had been achieved. Further improvements were required in the area of medication management.

On the day of inspection, inspectors found some PRN medicine was not available within the centre. This was also identified within the previous inspection.

Inspectors were informed some medications used within the designated centre were required to be split, and staff members identified the remainder of the tablet was returned to the pharmacy. Inspectors viewed the record for returned stock and found the specific medication was not listed as returned. Inspectors also found the amount of medication ordered did not correspond to the amount required if medication was returned. Inspectors also found a container within the medication press contained the name of the specific medication; however, this medication was split into unequal parts. Inspectors were not assured that correct administration of this medication occurred if staff were administering from the container.

Inspectors also viewed one incidence were a resident was prescribed 10 to 15 milligrams of a specific medication as a PRN. No guidelines were present to identify when the lesser dosage was to be administer compared to the higher. Staff members spoken with were unclear, some identified they would administer the dosage in two stages. Inspectors were informed, this once off prescription had been administered, however, on the day of inspection, inspectors viewed the medication within the medication press. The rationale for this additional dosage being present within the designated centre was unclear.

Some medications did not contain an expiry date within the label and staff members identified the expiry date was three months from the date of dispatch. However, the clinical nurse manager identified it was six months from the date of dispatch.

Rescue medication was viewed by inspectors this was within the expiry date.

Inspectors viewed administration sheets and found one medication was not administered as prescribed, this was highlighted to staff members on the day of inspection.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. However, inspectors found this policy was not always adhered to within the designated centre.

Inspectors crossed checked balances of some medication and found accurate records maintained.

Medication was supplied to the designated centre by a local pharmacist within the community house and from the organisations based pharmacy within the units, medication was recorded when received.

There was a system in place for recording, reporting errors and reviewing medication. Inspectors viewed incidents which occurred within the designated centre, however, there was no evidence of learning from some of these incidents to mitigate the risk of future reoccurrences.

Inspector found the signature bank within the designated centre was completed.

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.

Judgment:
Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors did identify some improvements in the governance and management of the designated centre and one of the two actions had been achieved. However, further improvements were required in the area of oversight to ensure safe, consistent and effective delivery of care in accordance with residents' needs were provided. This was

evident through the findings of this inspection within the outcomes inspected and the level of non-compliances identified.

Inspectors found there was 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 incidences of this during the inspection as staff members informed inspectors they did not know who the manager was on the day of inspection. Inspectors asked staff members how they would find out this information and staff members identified they would wait until they received a call from whatever manager was on duty. Staff members identified that depending on the manager on duty, practices differed. In some cases staff from another unit within the designated centre covered staff members break and administered medication if only one nurse was on duty, however, in other incidences it was the manager who provided this cover.

Inspectors viewed minutes of regular staff meetings within the designated centre.

The person in charge met with a clinical nurse manager three to discuss areas in relation to the designated centre.

Inspectors viewed minutes of meeting involving the person in charge and the provider, these meetings discussed organisational issues including staffing, policies and audits.

Inspectors found an annual review of the quality and care was completed in this designated centre for 2016, consultation with residents and their representatives was outlined within the document as questionnaires were sent out to family members.

The provider had carried out an unannounced visit on a six monthly-basis in 2016 to the three locations in operation as one unit was closed for renovations. One visit was completed in 2017, however, this was the renovated unit and the other three locations had not received a visit to review the safety and quality of care and support provided in the designated centre.

Inspectors viewed some audits in place and these contained an action plan and a timeframe for completion.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

Findings:
The designated centre did not always have sufficient staff numbers with the right skill mix, qualifications and experience to meet the assessed needs of the residents.

Inspectors reviewed the proposed and actual staff rota and found these were not accurately maintained. On the day of inspection, inspectors found several staff members in one unit who were not reflected on the rota. This was also identified in the previous inspection. Inspectors found there were some improvements in ensuring continuity of care to residents, however, on viewing the rota relief and agency staff were required on a daily basis. The improvement observed was in relation to staff members from resident's day centres supporting care to residents within the units each morning. These members of staff were aware of the shifts allocated to them three weeks in advanced, however, the rota within the units did not contain this information. On the day of inspection, the member of staff on the rota for the day was unaware of who the manager was and what staff members were coming onto the unit later in the evening. The centre had vacancies in staffing which were not always filled by relief or agency staff. On the day of inspection, inspectors identified an additional staff member was present within the centre in the morning. Inspectors requested clarity in relation to this and was informed there was no reason for this and they would await a call from management to relocate the additional staff member. Inspectors found the system was unclear, as the previous day a required shift remained unfilled and on the day of inspection an extra staff member was present without any rationale. The centre manger informed, inspectors that the centre was implementing a new rostering system to address rostering and consistency issues.

The centre had a yearly performance appraisal system in place, inspectors requested to view three of these. One staff member did not have any in place and the second one viewed contained minutes of a meeting and a performance development plan not relevant to the staff member. The manager on the day informed inspectors that a formal supervision system was planned for the centre.

Staff training records were reviewed and the inspectors found that not all staff had up-to-date training in manual handling and fire safety. This had been identified by the centre and dates had been scheduled to ensure all staff had up-to-date training.

Inspectors reviewed a sample of staff files and found that the files contained all the information required by Schedule 2 of the Regulations. There were no volunteers active within the 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found two of the three actions had been achieved and the policies were in place as outlined in Schedule 5. However, not all policies were reviewed within the last three years, for example, staff training and development was dated 2009.

No other aspect of this outcome was reviewed as part of this inspection.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004924
Date of Inspection:	20 June 2017
Date of response:	12 July 2017

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:
One resident purchased items prescribed for them from their own funds.

1. Action Required:
Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the

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

nature and extent of the resident's disability and assessed needs and his or her wishes.

Please state the actions you have taken or are planning to take:
PIC will follow up with families and ensure documentation is updated to ensure clear evidence is available regarding need for expenditure, consultation with family and agreement regarding amount of expenditure.
Documentation will be held in narrative notes under finance section of individual folder.

Proposed Timescale: 21/07/2017

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 goals set were not reviewed to assess the effectiveness of the goal nor was there evidence of progression in relation to some areas identified.

2. 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:
A schedule of reviews by Keyworkers and managers has commenced of individual's health and social care plans.
On review, each plan will be evaluated for its effectiveness on delivering on outcomes of the individual goals.

Proposed Timescale: 11/08/2017

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:
Equipment labelled as single use items by the manufactures were used multiple times over a number of days.

An infectious disease was not clearly outlined in relation to the management of wound sites.

3. 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:
All single use equipment has been identified and is discarded after use.
New order for single patient items has been requested and associated cleaning regime will be in place.
The individual care plan relating to the presence of a HCAI has been updated and communicated with staff,

Proposed Timescale: 12/07/2017

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:
Staff members were not guided effectively in the administration of PRN medicine to support residents to manage their behaviours.

4. 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:
Guidance for staff will be communicated and included at team meetings regarding the practice of evaluating the effectiveness of a dispensed PRN after 30 mins.
This guidance will be updated in relevant Personal Care Support Plans under How to Support me if I become distressed when these are being reviewed.
An audit of all PRN's in DC1 will be completed to ensure prescribing instructions on indications for administration are clear to guide staff practice.
GP prescribers and mental health team prescribers will be communicated with on this issue with the support of the Pharmacist.

Proposed Timescale: 11/08/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two staff members required training in the management of behaviour that is challenging including de-escalation and intervention techniques and five staff required refresher training.

5. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
Two staff are scheduled to attend MAPA training on August 16th 2017

Proposed Timescale: 16/08/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The rationale for the use of a visual monitor was unclear within the centre.

6. 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:
A risk assessment has been completed and the safety plan indicates the rational for the use of the non recordable visual monitor as a risk control measure.
Staff have completed a right referral form and case will be included on agenda of RRC in September 2017
The use of this monitor will be included on the quarterly notifications to HIQA

Proposed Timescale: 26/09/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One staff member was unclear in relation to what was the procedure should an allegation of abuse arise within the centre.

Another staff member required refresher training in the area of adult protection and safeguarding training.

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

Please state the actions you have taken or are planning to take:
The procedure in the case of an allegation of abuse will be covered as an agenda item at all scheduled Team Meetings with residential staff, day service staff & support team staff.
Staff requiring training is scheduled for July 12th 2017.

Proposed Timescale: 28/07/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The details contained within some plans did not guide staff effectively to ensure some residents received the required healthcare provision.

The review process in place for identified healthcare areas required improvement to identify the effectiveness of the interventions implemented to ensure these were having a positive impact on resident's healthcare needs.

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

Please state the actions you have taken or are planning to take:
The scheduled review process for individual plans will evaluate the effectiveness of the interventions.
The documentation within each plan will be reviewed to ensure they guide staff practice.

Proposed Timescale: 11/08/2017

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:
Some PRN medicine was not available within the centre.

The system in place for administering medication which required alteration from the dispensed dosage was unclear.

The administration for some PRN was unclear in relation to once off prescriptions.

The rationale for additional once off PRN medication present in the designated centre was unclear.

One medication was not administered as prescribed.

Some medications did not contain an expiry date.

There was no evidence of learning from some medication errors to mitigate the risk of future reoccurrences.

9. 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:
All staff have been advised to familiarise themselves with the Cheeverstown Medication Administration and Management Policy & Procedures.
Training for staff on the Medication Policy and procedures will commence in September.
Trends and learning from medication errors will be included as an agenda item monthly at the staff team meetings
Pharmacist and GP will commence review of PRN prescriptions to ensure it guides staff practice for administration.

Proposed Timescale: 29/09/2017

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 lines of accountability were unclear among the layers of management within the designated centre.

10. 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:
Contact/lead staff on shift will ensure manager and staff rosters are present, current and communicated to staff team on duty.

Proposed Timescale: 21/07/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All locations within the designated centre had not received an unannounced visit at

least once every six months for 2017.

11. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
The Registered Provider will carry out an unannounced visit in all locations across the DC every six months and prepare a report on the safety and quality of care and support.
The recommendations and action plan will be discussed with the Person in Charge.

Proposed Timescale: 31/12/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not always sufficient numbers of staff to meet the assessed needs of the residents.

12. 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:
PIC, CNM3 & Head of campus in conjunction with HR have engaged in active recruitment for vacancies.
Appointments to DC1 of two new staff members is scheduled for end of August

Proposed Timescale: 31/08/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff rota was not accurately maintained

13. 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:
Day care support staff are now scheduled and named on a Friday for the following week.
Managers keep a record of actual staff assigned/allocated to a house/location on the actual staffing, accounting for redeployment if it is required for instance in the case of sick leave.
Core Support staff will be identified and allocated for the designated centre.

Proposed Timescale: 28/07/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up-to-date training as outlined in the report.

14. 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:
2 staff are scheduled to attend MAPA on Aug 16th
1 staff is scheduled to attend Safeguarding refresher training on July 12th
1 staff completed fire safety on June 26th and other staff are scheduled to attend training on July 17th
Staff are scheduled to attend Safe Moving and People Handling on 19th July & August 3rd.

Proposed Timescale: 16/08/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no formal supervision arrangements in place.

15. 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:
CNM 1's are rostered for at least 19.5 hours into locations to provide support mentorship and supervision for staff.
The person in charge has organised a schedule of performance management meetings with staff with support from the CNM1's and CNM3

Proposed Timescale: 31/12/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all policies were reviewed within the last three years, for example the staff training and development policy

16. 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:
Updated Staff Training & Development Policy draft from HR is scheduled for circulation for comment on July 12th 2017.
Staff Training & Development Policy is scheduled for implementation across the service commencing July 31st 2017

Proposed Timescale: 31/07/2017