

**Health Information and Quality Authority
Regulation Directorate**

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



| | |
|---|--|
| 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 CLG |
| Lead inspector: | Maureen Burns Rees |
| Support inspector(s): | None |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 12 |
| Number of vacancies on the date of inspection: | 8 |

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

| | |
|---------------------|---------------------|
| From: | To: |
| 17 April 2018 09:30 | 17 April 2018 17:00 |
| 18 April 2018 09:30 | 18 April 2018 16:00 |

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

| |
|---|
| 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 14: Governance and Management |
| Outcome 17: Workforce |

Summary of findings from this inspection

Background to the inspection:

This centre, along with three other centres run by the provider, was placed on a six month regulatory plan by HIQA starting in February 2018. The regulatory plan was put in place as a result of significant non-compliances identified in centres on the campus. It is proposed that a registration decision will be made at the end of the regulatory process for each of the centres. Three of the centres have not had a registration decision made to date.

This centre was registered in April 2017. However, the centre's registration was subject to a non-standard condition which required that the provider implement and adhere to action plans submitted in respect of an inspection completed in October 2016. The latter inspection had found non compliances across a number of outcomes. A follow-up inspection was completed in June 2017 but found that the action plan had not been adhered to in a significant number of areas and had not brought about compliance.

How we gathered our evidence:

As part of the inspection, the inspector met with the person in charge, the head of care, the chief executive officer, two staff nurses, four social care workers and one

housekeeper. Each of the four houses were visited. Residents were met with, in each of the houses with the exception of the respite house which was closed over the two days of this inspection. The inspector met with nine of the 12 residents living in the centre at the time of inspection. Residents spoken with outlined that they enjoyed living in the centre. All of the residents were in good spirits and were observed to have warm interactions with the person in charge and staff caring for them. The inspector reviewed care practices and documentation such as care plans, medical records, accident logs, policies and procedures and daily records.

Description of the service:

The designated centre consisted of four houses. Three of the houses provided full-time residential care for adults over the age of 18 years. The fourth house provided a respite service for adults and children, with adults attending at a separate time to children. One of the houses was located in the community in Dublin 24 whilst the other three houses were located within a campus based setting operated by the provider. The service provided was described in the provider's statement of purpose, dated February 2018. Each of the residents had their own bedrooms which had been personalised to their own taste. There was adequate communal space within each of the houses. The three houses located on the campus had a number of communal garden areas within the campus. The fourth house in the community had a nice sized garden to the rear of the centre.

Overall judgment of our findings:

Overall, the inspector found that there had been significant improvements since the last inspection and that the provider had put in place a number of additional systems to ensure that the majority of regulations were being met or were in the process of being met. A governance plan and an urgent action plan had been put in place to address issues and non compliances identified. Senior management team walk arounds had been introduced on a weekly basis to quality check those actions marked as complete on the urgent action plan.

The person in charge had been in the post for an extended period and demonstrated adequate knowledge and competence during the inspection. The inspector was satisfied that she was a fit person to participate in the management of the centre. There remained some areas for improvement as listed below and within the body of the report.

Good practice was identified in areas such as:

- Appropriate safeguarding arrangements were in place. (Outcome 8)
- Arrangements were in place to support residents on an individual basis to achieve and enjoy the best possible health. (Outcome 11)
- There were systems in place to support staff in protecting residents in relation to medication management. (Outcome 12)

Areas for improvement were identified in areas such as:

- Resident's individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified. However, improvements were required so as to ensure that: recommendations from members of the multidisciplinary team were reflected in personal plans and, that residents family

representatives were involved in the reviews of personal plans put in place.
(Outcome 5).

- Risk management arrangements required some improvements. (Outcome 7)
- There were a small number of staff vacancies at the time of inspection and formal supervision arrangements for staff were not in place (Outcome 17)

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 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):

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

Findings:

Resident's individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified. However, improvements were required so as to ensure that: recommendations from members of the multidisciplinary team were reflected in personal plans and, that residents family representatives were involved in the reviews of personal plans put in place.

A full assessment of resident's needs was completed. A 'meaningfull activity' assessment had also been completed for individual residents. These assessments informed personal plans and a newly introduced 'my life plans'. Plans in place detailed the individual needs and choices of residents but it was not always clear if the resident's family were involved in formulating the plans. Personal goals and actions required to achieve same were recorded for individual residents. A new template to evaluate goals set had recently been introduced.

Multi-disciplinary team meetings for individual residents had been introduced across the centre since the last inspection. In a sample of files reviewed there was evidence that recommendations from professionals at these meetings were reflected in personal plans. However, this was not found to be the case in one file reviewed.

The inspector reviewed records of 'my weekly plans' for individual residents which showed that they were engaged in a fair range of activities in the local community and inside the centre. Visual timetables had been put in place for residents regarding their daily planners. Residents and staff were observed to refer to their activity timetable and it was evident that it assisted them in organising their day.

Personal plans were formally reviewed on a minimum of a yearly basis. However, some reviews undertaken did not assess the overall effectiveness of the plans and did not involve the residents family or representative.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

The design and layout of the centre reflected the layout as described in the centre's statement of purpose. However, there were some maintenance works required in one of the units and outdoor facilities for children attending respite in the centre required improvement.

The designated centre consisted of four houses. Three of the houses provided full-time residential care for adults over the age of 18 years. The fourth house provided a respite service for adults and children, with adults attending at a separate time to children. One of the houses was located in the community in Dublin 24 whilst the other three houses were located within a campus based setting operated by the provider.

Each of the houses were tastefully decorated to meet residents needs. Residents had their own bedroom which had been personalised to their own taste. There was adequate communal space within each of the houses. Each of the houses had a fully equipped kitchen and there was dining areas with sufficient space to make meal times a social occasion. However, it was noted that the house in the community was in need of some maintenance and refurbishment works. This included, repainting of some walls and woodwork, repair of leak in roof and, replacement of area of flooring in the hallway.

The three houses located on the campus had a number of communal garden areas within the campus. The fourth house in the community had a nice sized garden to the rear of the centre. The respite house which was used by children on alternate weeks was located on the campus and availed of a communal garden area. However, there were minimal recreational facilities in this area for children to play in contrary to the requirements of the regulations.

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):

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

Findings:

There were arrangements in place to promote and protect the health and safety of residents and staff.

Suitable precautions were in place against the risk of fire. A procedure for the safe evacuation of residents and staff, in the event of fire, was prominently displayed in each of the houses. Each of the residents had a personal emergency evacuation plan in place which considered the mobility and cognitive understanding of the resident. Each of the houses had suitable night time staffing arrangements so as to ensure the safe evacuation of residents in the event of fire. The fire assembly point was identified with appropriate signage in an area to the front of each of the houses. Fire drills involving residents were undertaken at regular intervals with appropriate records maintained of those attending, time required for full evacuation and issues encountered. A fire risk assessment had been undertaken. Records showed that fire fighting equipment, fire alarms and emergency lighting were appropriately installed and serviced by an external company. Formal safety checks of fire equipment and other safety precautions were undertaken at regular intervals.

There was a risk management policy in place, dated April 2015, which was in the process of being reviewed. Individual risk assessments for residents had been undertaken with plans put in place to address risks identified. Site-specific risk assessments had been undertaken and appropriately recorded. A risk register was maintained as a 'living' document in each of the houses. There was a health and safety policy and procedure, which was specific to the centre. Health and safety checks were completed at regular intervals. There was an emergency plan in place to guide staff in responding to an emergency. The provider had a risk management department which was accessible as a resource for the centre.

There were arrangements for investigating and learning from serious incidents and adverse events involving residents. From a review of a sample of case notes, the inspector found that incidents had been appropriately reported with a record maintained of actions taken and further actions required. There was evidence that individual incidents were reviewed and discussed at staff team meetings. The providers risk

management department had completed an analysis and trending report of the number and type of incidents across the centre and compared to centres across the service. This provided opportunities for shared learning across the service.

There were procedures in place for the prevention and control of infection. At the time of the last inspection, the inspector identified that equipment labelled as a single use item by the manufacturer were used multiple times over a number of days. This practice had since ceased and all equipment used was found to have been appropriately cleaned and or disposed off as required. There was an infection control policy and procedure. There were cleaning schedules in place and sign off sheets. Colour coded cleaning equipment was in place and appropriately stored. The inspector observed that there were facilities for hand hygiene available. All areas were observed to be clean.

Judgment:

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):

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

Findings:

There were measures in place to safeguard residents and appropriate actions had been taken in response to allegations or suspicions of abuse.

There was a policy and procedure on protection of vulnerable persons, dated March 2015, which was in line with the national guidance. The person in charge and staff interviewed were knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. This had not been the case at the time of the last inspection. There had been a small number of suspicions of abuse in the previous 12 month period and these were found to have been appropriately responded to. Risk assessments and safeguarding plans had been put in place where required. There was evidence that safeguarding arrangements were regularly discussed at staff handover with a 'safety pause' and at team meetings, The providers safeguarding officer had visited individual houses to brief staff.

Arrangements were in place to provide residents with emotional and behavioural support

that promoted a positive approach to the management of behaviour that challenges. The centre had a policy on promoting positive approaches, dated February 2017. Positive behaviour support plans had been put in place for residents who were identified to require same. Training records showed that staff had received appropriate training in a recognised behaviour management approach. Staff interviewed were familiar with the management of challenging behaviour and de-escalation techniques.

There was a policy and procedure on restrictive practices. Restrictive practices in place were approved and regularly reviewed by the provider's behaviour support team. At the time of the last inspection, a restrictive practice was identified which had not been recorded by the provider as a restrictive practice and had not been reported to HIQA. Since that inspection the identified restriction was no longer in use. A restoration of rights review meeting had been introduced whereby restrictive practices in place were reviewed by a resident's keys worker and the person in charge to determine if the restriction was still required. There was a restrictive practice log maintained. Risk assessments had been completed for restrictive practices in place.

The centre had an intimate care policy in place. Intimate care assessments and plans were in place for residents who required same. These were found to provide a good level of detail to guide staff in meeting the intimate care needs of these residents.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Arrangements were in place to support residents on an individual basis to achieve and enjoy the best possible health.

Residents' healthcare needs were met by the care provided. A number of the houses had a registered staff nurse on duty at all times whilst other houses had access to a staff nurse within the campus. At the time of the last inspection, the inspector had found that the details contained within some plans did not guide staff effectively. On this inspection and of the sample of files reviewed, it was found that a comprehensive health assessment and plans had been completed for residents. A hospital passport was in place which included pertinent information in the event that a resident needed to be admitted to hospital. Records were maintained of all contact with GPs (general

practitioner) and other health professionals. Each of the residents had their own GP and access to an out-of-hours doctors service. A GP attended two days a week an office on the campus which was considered convenient. Residents had access to a number of other therapeutic supports. These included: speech and language therapy, dietician, physiotherapy and clinical nurse specialists.

There were arrangements in place for residents to be involved in choosing and assisting to prepare meals in individual houses. Each of the houses had a fully equipped kitchen with adequate seating to allow meal times to be a social occasion. A weekly menu planner was agreed with residents. There was a policy on diet and nutrition. The inspector observed that a healthy diet and lifestyle was promoted in the centre. Feeding, eating, drinking and swallowing (FEDS) assessments had been completed for residents identified to require same. Specific plans put in place and recommendations from dieticians were found to be implemented.

Judgment:

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):

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

Findings:

The systems in place to support staff in protecting residents in relation to medication management were found to be satisfactory on this inspection.

There was a policy and procedure on medication administration and administration. A secure storage press was in place in each of the houses, including appropriate arrangements for the storage of controlled drugs where in use. Registered staff nurses were responsible for the administration of medications across the centre. Staff spoken with had a good knowledge of the requirements for the safe administration and management of medications. The inspector reviewed a sample of medication prescription and administration records and found that they had been appropriately completed and were regularly reviewed by the residents general practitioner (GP). A sample of records reviewed showed that medications had been administered as prescribed. Individual medication management plans were in place. Procedures were in place to check all medications ordered and delivered by pharmacy with medication stock control logs maintained.

PRN or as required medication protocols were in place for residents who were identified

as requiring these. These had been signed off by the resident's physician. A PRN administration record was maintained of all administrations. On the last inspection, it was identified that some PRN medications prescribed were not available within the centre. On this inspection an adequate supply of all medications were found to be in place.

A small number of controlled drugs were used in one of the centres. These drugs were found to be appropriately stored with checks recorded in the controlled drugs register.

There were arrangements in place to review and monitor safe medication management practices in the centre. Medication audits were undertaken on a regular basis. There was evidence that the output from these audits, with any learning identified was discussed at staff team meetings.

There were procedures for the handling and disposal of unused and out of date drugs, including controlled drugs. A record was maintained of all unused and out of date medication returned to pharmacy which were signed by the pharmacist and the staff returning the medications.

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:

Arrangements in place to monitor the quality and safety of care and support in the centre had improved since the last inspection. However, some improvements were required so as to ensure that the person in charge received appropriate supervision and for the provider to comply fully with the requirement to complete six monthly unannounced visits to the centre.

There was a management structure in place. The person in charge reported to the head of care who in turn reported to the chief executive officer. Staff interviewed had a clear

understanding of their role and responsibility, and of the reporting structure. At the time of the last inspection, the lines of accountability within the centre was not clear. Since that inspection, changes had been made to the roster system with the introduction of an electronic roster to replace the printed rosters in each house, so that any changes made to the roster by a manager or the rostering team were immediately available within each house. Lead staff member on each shift was clearly indicated on the rosters reviewed on this inspection.

The person in charge held a full-time position and was not responsible for any other centre. She was supported by two clinical nurse managers. The person in charge had been manager in the centre for the past two years but had more than 12 years management experience and 30 years of experience working within the service. She was a registered nurse in intellectual disabilities and held a degree in nursing. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards and had a good understanding of the individual care needs of each of the residents. However, the person in charge had not had formal supervision or performance review with her line manager for an extended period. It was noted that she had regular informal contact with her line manager but formal arrangements to ensure that she performed her duties to the best of her ability were not being adhered to in line with the providers policy.

This centre is one of four centres operated by the provider which was placed on a six month regulatory plan by HIQA starting in February 2018. As a consequence the provider had put in place a governance plan and an urgent action plan to address non compliances identified in previous inspections. A range of audits had been undertaken in the centre as part of an audit cycle. These included audits of personal plans, medication management and residents finances. There was evidence that issues identified were reported to the senior management team with an action plan and timelines to address issues identified. A schedule of walk-rounds by members of the senior management team had been undertaken to quality check against those actions marked as complete on the urgent action plan and assurance statement to HIQA. An annual review of the quality and safety of care as required by the regulations had also been completed. However, unannounced visits to the centre on a six monthly basis, as per the requirements of the regulations were not being fully complied with. An unannounced visit had been undertaken to part of the centre in February 2018 but it did not adequately cover all areas.

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:

Overall the staff numbers and skill-mix were appropriate to meet the assessed needs of residents in the centre. However, there were a small number of staff vacancies at the time of inspection and formal supervision arrangements for staff were not in place.

There was a staff roster in place which showed that there were adequate numbers and skill-mix of staff on each shift to meet the needs of the residents. Since the last inspection, the staff rosters had been changed to ensure more appropriate staffing in some areas. The roster had also been computerised which facilitated it being a 'living' document which was coordinated and maintained centrally. The person in charge reported that the whole time equivalent staff complement for the centre was short by three and a half staff. There was evidence that recruitment was underway for these positions. It was noted that a regular panel of relief staff were used to cover staff vacancies which provided some consistency of care for the residents.

The inspector noted that copies of the standards and regulations were available in the centre. Staff interviewed were knowledgeable about their role and of the regulatory requirements.

There was a training and development procedure in place. There was a training programme in place which was coordinated centrally by the provider. Staff training records reviewed by the inspector showed that all staff had attended mandatory training. Some other training to meet specific needs of residents had been identified and sourced.

There were limited formal supervision arrangements in place for staff. This had been highlighted on previous inspections and meant that staff might not be appropriately supported or have appropriate oversight so as to ensure that they are performing their duties to the best of their abilities. It was noted that an annual performance review was completed.

There were no volunteers working in the centre at the time of 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:

Maureen Burns Rees
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: | A designated centre for people with disabilities operated by Cheeverstown House CLG |
| Centre ID: | OSV-0004924 |
| Date of Inspection: | 17 April 2018 |
| Date of response: | 29 May 2018 |

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 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 reviews undertaken did not involve the residents family or representative.

1. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and

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

where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Families will be invited to participate in the review of the resident's personal plan annually. This annual review will be aligned with the MDT meeting.

Residents (when appropriate) and their families are invited to be present and participate in multidisciplinary team case conferences. 1 resident has had a case conference since the inspection date with family involvement. There are 3 further case conferences planned and will be completed by the end of August.

Proposed Timescale: 31/08/2018

Theme: Effective Services

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

Some reviews undertaken did not assess the overall effectiveness of the plan.

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:

There are 12 residents in DC1. The PIC has commenced the review of the personal plan with the DC team. 9 residents have had a review completed since the date of inspection; the remaining 3 residents have a scheduled review and will be completed by mid-June. The scheduled date is in keeping with family member's availability to meet. My Life Plan training includes giving staff guidance on how to review the effectiveness of a plan.

The PIC is taking measures to optimise family participation, in particular in relation to 'My Life Plan' review / social goals review.

Families will be invited to participate in the review of the resident's overall personal plan annually.

Proposed Timescale: 17/06/2018

Theme: Effective Services

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

Multi-disciplinary team meetings for individual residents had been introduced across the centre since the last inspection. In one file review it was noted that recommendations from a health professional recorded at this meeting were not reflected in the identified

residents personal plan.

3. Action Required:

Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

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

The PIC has reviewed the recommendations of the MDT meeting held in March and there is evidence of documentation and follow through on recommendations arising. The recommendation for the resident identified on the day of inspection is now complete - A Samsung Tablet has been purchased for the resident

Proposed Timescale: 28/05/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

It was noted that the house in the community was in need of some maintenance and refurbishment works. This included, repainting of some walls and woodwork, repair of leak in roof and, replacement of area of flooring in the hallway.

4. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

The leak in the roof has been repaired.

The flooring has been repaired and is no longer a health & safety concern. It will be replaced within the next 2 weeks to prevent the problem reoccurring.

The painting will be completed within 4 weeks.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

The respite house which was used by children on alternate weeks was located on the campus and availed of a communal garden area. However, there were minimal recreational facilities in this area for children to play in.

5. Action Required:

Under Regulation 17 (3) you are required to: Where children are accommodated in the designated centre provide appropriate outdoor recreational areas which have age-

appropriate play and recreational facilities.

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

There is a children's playground onsite on campus at the school. Children can avail of this recreational area for play when in respite in DC1 on campus

Proposed Timescale: 29/05/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The person in charge had not had formal supervision or performance review with her line manager for an extended period. It was noted that she had regular informal contact with her line manager but formal arrangements to ensure that she performed her duties to the best of her ability were not being adhered to in line with the providers policy.

6. 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 person in charge will have an annual performance review completed within the next 2 weeks.

Supervision from the Head of Campus and PIC will take place quarterly, with a focus on support of the PIC in carrying out her regulatory function and Cheeverstown policy and practice.

Proposed Timescale: 15/06/2018

Theme: Leadership, Governance and Management

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

Unannounced visits to the centre on a six monthly basis, as per the requirements of the regulations were not being fully complied with. An unannounced visit had been undertaken to part of the centre in February 2018 but it did not adequately cover all areas.

7. 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 (or nominee) will complete an unannounced visit to DC1 6 monthly.

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

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

The person in charge reported that the whole time equivalent staff complement for the centre was short by three and a half staff.

8. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

The 3 vacant positions are maternity leave short term vacancies. Recruitment efforts to fill these vacancies on a specified purpose contract have been unsuccessful to date, but efforts are ongoing.

Vacant shifts are therefore filled by Support Team members familiar with the support needs of the residents in DC1. The use of unfamiliar agency staff is a last resource.

The remaining vacancy is in Beeches 5 respite – these shifts are filled by regular core support team members. Respite vacancies are currently advertised internally and externally.

Proposed Timescale: 30/09/2018

Theme: Responsive Workforce

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

There were limited formal supervision arrangements in place for staff.

9. 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:

Staff will receive formal supervision by a line manager quarterly. This meeting will compose of one Performance Development Planning meeting and 3 formal supervision meetings. The PIC will schedule staff a date for this supervision. Staff will receive one to one management supervision within the next 3 months

Proposed Timescale: 31/08/2018