<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Centre 2 - Cheeverstown House Residential Services (Active Age)</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004925</td>
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<td>Centre county:</td>
<td>Dublin 6w</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Cheeverstown House Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Paula O'Reilly</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Karina O'Sullivan</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>15</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
• to monitor compliance with regulations and standards
• following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
• arising from a number of events including information affecting the safety or well-being of residents

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

**The inspection took place over the following dates and times**

From: 12 October 2017 09:15  
To: 12 October 2017 19:00  
13 October 2017 09:45  
13 October 2017 20:00

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

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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 13: Statement of Purpose</td>
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**Summary of findings from this inspection**

Background to the inspection:

An initial inspection in 2014, was completed as a result of the provider submitting an application to register this designated centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, at the time, this 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 the Health Information and Quality Authority (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 clear lines of authority and accountability. Subsequently in early 2016, HIQA issued the provider with a timeline to implement appropriate arrangements in relation to persons in charge being assigned to centres.

The provider responded by appointing persons in charge in each designated centre. The purpose of this inspection was to inform a registration decision and to ensure the revised governance arrangements were having positive outcomes for residents. The inspector also followed up on the actions from the previous inspection, to ensure agreed actions were being implemented. This inspection was completed over two days.

HIQA were provided with information by Cheeverstown CEO and Board in September 2017 regarding an external concern. This related to the financial processes in place for residents in a number of designated centres as operated within the Cheeverstown financial department. The inspector was informed a review was due to commence in relation to this issue. However, during this inspection some resident's finances were found not to be appropriately managed from an organisations perspective.

How we gathered our evidence:
As part of the inspection, the inspector visited the four houses within the designated centre and met with fifteen residents, spoke with three residents and five staff members. The inspector viewed documentation such as care plans, person-centred support plans, recording logs, policies and procedures.

Description of the service:
This designated centre consisted of four houses based within the campus operated by Cheeverstown House Residential Services. The provider had produced a document called the statement of purpose, as required by regulation. The designated centre aimed to provide residential 24 hour care to male and female adults with intellectual disabilities.

Overall judgment of findings:
Some changes had occurred since the previous inspection, yet, the inspector found that significant progress was not evident in order to bring about compliance with the regulations and improve the quality of life residents' experienced while living in this centre. For example, residents social care needs were poorly met within the centre and appropriate measures to ensure residents were safeguarded were not in place. In addition, staffing members were not allocated based on residents' needs and relief staff members were regularly used resulting in lack of continuity of care provision for residents.

This inspection report identified 31 actions in need of address, resulting in four outcomes being evidenced as majorly non-compliant:

Outcome 5: Social Care Needs
Outcome 8: Safeguarding
Outcome 14: Governance and Management
Outcome 17: Workforce

These areas required significant improvement to ensure that effective systems were implemented in the monitoring of the quality and safety of the care provided in the centre.

Out of the remaining 14 outcomes inspected against, six were found to be in moderate non-compliance, three were substantially compliant and five were compliant.

The person in charge facilitated the inspection along with a clinical nurse manager one.

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:
Residents’ privacy, dignity and respect was not always upheld by practices within the centre. The inspector observed evidence of institutional type practices in operation within the homes of residents.

A sample of residents’ finances were reviewed, the inspector found some residents paid for items such as, medical procedures, prescribed medical products, food items and car parking while one resident attended a clinic appointment. The inspector requested to view evidence of the consultation which took place to result in this practice, however, this was not available.

The inspector reviewed an incident where a resident had left their own house and entered another house. In response to this, to mitigate reoccurrence, the external doors in the other house were locked, therefore placing a restriction on residents. There was no evidence that the residents had been consulted with regarding this, it was also evident that this had not been reviewed. The inspector was not assured that the rights of residents were upheld in relation to the locking of doors.

The inspector observed further routines and practices which did not promote resident’s independence or choice or privacy and dignity. The practice of night checks were evident within the homes of residents without a clear rationale based on an assessment of resident’s needs in place.

The inspector viewed the complaints log within the centre. There was evidence that
complaints were followed up on and resolutions were sought, however the timeline for one compliant viewed was four months in relation to a clothing issue. The person in charge identified why this time line occurred, however, this was not evident within the complaint document.

The inspector viewed minutes of residents' meetings within three of the houses, some of these were limited for example, four meetings had occurred in one house in 2017.

The inspector viewed signs placed at the entrance to each house requesting people entering the house to knock or ring the door bell before entering into the house. During the two days the inspector observed this practice occurred.

Interactions, observed among staff members and residents, were found to be respectful and dignified in manner.

**Judgment:**
Non Compliant - Moderate

**Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There were systems in place to assess resident's communication needs and to provide supportive interventions as required. However, residents did not have access to the internet within the four houses, this was also identified on the previous inspection.

The organisation had a policy in place in relation to communication.

The inspector viewed four residents' individual communication requirements which were highlighted in their personal plans. The communication section provided essential information on supporting residents to communicate and assist staff members to engage with residents. From the sample of communication profiles viewed some of these included specific phases or actions residents used to communicate their needs effectively to members of staff. One resident was waiting to commence on a digital system to communicate their needs.

Over the two days the inspector observed staff members communicating with residents in accordance with their assessed communication needs.
**Judgment:**
Substantially Compliant

### Outcome 03: Family and personal relationships and links with the community
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Residents were supported to develop and maintain personal relationships with family members. However, links with the wider community were very limited.

Family members were encouraged to get involved in the lives of residents in accordance with residents’ preferences. Family members could and did visit the designated centre on a regular basis. This was also evidenced through the records maintained within residents files. Residents also had pictures of family members in the centre.

There was also a policy in place which outlined that visitors were welcome in the centre.

**Judgment:**
Substantially Compliant

### Outcome 04: Admissions and Contract for the Provision of Services
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

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

**Findings:**
The centre had a policy on admission which outlined the arrangements in place for admitting and transferring residents within the centre.
The inspector viewed a sample of five contracts of care and found that one resident had no contract of care in place. The other four residents had written agreements, however, these did not outline the services to be provided and all of the fees to be charged. The provider nominee identified during the feedback session that the organisation was currently in the process of reviewing the contracts of care.

**Judgment:**
Non Compliant - Moderate

**Outcome 05: Social Care Needs**
*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his/her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**
Effective Services

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

**Findings:**
Residents did not have the opportunity to participate in meaningful activities that were appropriate to their interests and preferences. In addition, staff members were not guided effectively as some residents did not have up-to-date personal plans in place. The inspector viewed a sample of nine residents' personal social plans, however, only half of these had assessments completed. Therefore, it was unclear to the inspector how goals were identified as no assessment was completed.

Some goals identified were not social goals and related to healthcare issues such as, increasing muscle mass and weight management. Another plan viewed identified that the resident was not allocated a key worker to complete their plan. The reason for this was documented as due to staffing issues, this was dated 21 September 2016. The inspector requested to view evidence of a plan for this resident and was presented with minutes of a personal outcome measures meeting dated 21 April 2017, however, there was no identification of who attended this meeting. For another resident there was no plan or assessment in place, the inspector requested to view the previous plan and was presented with a 2015 assessment document which did not contain any goals, progress or review. Another resident had an assessment completed in 2015 and a plan dated 2016, there were no levels of progression within the goals identified within the plan. The inspector found the plans and the process in place to devise plans for residents' required
significant improvement.

The inspector viewed documentation in relation to activities and outings and found these were very limited. For example, one resident retired to their bedroom following attendance at their day service usually between 16:00hrs or 16:30hrs each day. This was recorded as relaxing in bedroom. No other activities were recorded for this resident during the week with the exception of nine outings outside of the campus since January during the weekends. The inspector viewed two other residents' activities, however, these were also limited for example, watching television was the main activity recorded most days with a number of days left blank. Staff members identified residents did not really partake in activities in the evening time. Other staff members identified activities could not be facilitated due to the shortage of staff members as one house in particular was reliant on relief staff members daily until recently.

**Judgment:**
Non Compliant - Major

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

**Findings:**
The location, design and layout of the centre was suitable and met residents' individual and collective needs in a comfortable way.

The centre comprised of four houses, all of which were located in a campus setting. Each resident had their own private bedroom, these rooms were decorated to their individual taste. There were separate kitchens with adequate cooking facilities and adequate communal space available in all houses.

**Judgment:**
Compliant

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

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

Findings:
There were systems in place to promote the health and safety of residents, visitors and members of staff. However, areas were identified in relation to risk management and fire management during this inspection.

There were systems in place for the prevention and management of fires. Certificates and documents were present to show fire alarms, emergency lighting and fire equipment were serviced by an external company dated 2017 as required by regulations. The procedures to be followed in the event of a fire were displayed in a prominent place, however, some staff spoken with were unsure of the process in terms of the evacuation procedure. Within one house, zones were identified within the fire alarm, however, it was not documented what part of the house was contained in each zone. The inspector requested to view fire drills, from these the inspector was not assured that all residents could safely evacuate the designated centre, as this information was not available on the day of inspection. The follow up to some fire drills was also absent for example, a piece of equipment was documented as required following one fire drill. The inspector requested to view this in place however, found this was not present.

The inspector also followed up on actions identified by an external fire consultant in 2014 and 2017 and requested clarification in relation to fire containment measures implemented following these reports as this was not available on the day of inspection.

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 risks. Risks included medication, falls, use of sharps and chemicals. There were individual risk assessments for residents in place, these included epilepsy, choking and infections. However, some of these required updating to reflect actual practice for example, interventions in place in relation infection prevention and control was not accurately reflected in the assessment viewed. The fire procedure at night time involved some houses and residents to be left without any staff member present, the inspector requested to view the risk assessment in place for this, however, this was not available.

There was a system in place within the centre to record accidents and incidents to ensure preventative measures could be implemented in order to mitigate reoccurrences. However, some of these reviewed were not appropriately followed up on, for example, one incident contained no follow up as the section was blank and other incident identified review of the resident’s behaviours support plan was required. On viewing the resident’s file and from speaking with staff the follow up documented within the incident form did not take place.
The centre had infection prevention, and control procedures in place. The inspector observed personal protective equipment and hand hygiene facilities were available in the centre.

The centre had an health and safety statement in place this was dated May 2016. This outlined the responsibilities of the various staff members within the organisation.

**Judgment:**
Non Compliant - Moderate

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**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. Improvements were required in relation to restrictive practice, behaviour management and the oversight of residents finances.

The inspector acknowledged the reduction in the level of physical restrictions in place for one resident. However, the current restriction in place required improvements to comply with regulations. These related to documenting a restrictive log outlining the type of restriction, date and duration the restriction was implemented. The inspector requested to view evidence that the restriction was reviewed by the rights committee, however, this was not available on the day of inspection. The inspector discussed this issue at the end of inspection with the person in charge and the provider nominee and requested evidence that this restriction was reviewed by the rights committee. This information was to be submitted to the inspector, however, no information was provided following inspection. The inspector also requested to view evidence that every effort to identify and alleviate the cause of residents' behaviour was made and that all alternative measures were considered before a restrictive procedure was used. However, this was not available nor was there evidence that the least restrictive procedure was implemented for the shortest duration necessary. The inspector viewed a behaviour support plan in place for this resident and the document stated the resident should not be in groups lager than five however, the resident lived in a house where six residents
were accommodated.

Restrictive procedures including chemical and environmental restraint were used, however, some of these were not used in accordance with evidence based practice. One resident was prescribed a PRN (a medicine only taken as the need arises) medicine to alter their behaviour. This medication was to be administered for severe agitation or obsessive symptoms or distress. The resident had a behaviour plan developed in February 2017, however, staff members were not guided appropriately in relation to the administration of this medication. The inspector viewed another behaviour support plan that clearly outlined the steps staff members were to follow in relation to the de-escalation process. Staff members spoken with provided inconsistent information in relation to what indicators would identify when the resident would require this intervention.

During this inspection, the inspector also found some resident's finances were found to be not appropriately managed from an organisational perspective.

The inspector spoke with members of staff and they were clear in relation to what was the procedure should an allegation of abuse arise within the designated centre. However, the inspector became aware from a review of residents’ files that a volunteer was present within the centre. The inspector requested evidence that this person had received training in the area of safeguarding residents and the prevention, detection and response to abuse, however, the inspector was informed volunteers were not provided with this training. The inspector was informed that volunteers could take residents around the grounds of the campus, the inspector was not assured that appropriate safeguarding measures were in place in this regard.

**Judgment:**
Non Compliant - Major

**Outcome 09: Notification of Incidents**
* A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
A record of all incidents occurring in the designated centre was maintained and where required, notified to the chief inspector. The person in charge was aware of the legal requirement to notify the chief inspector.
Judgment: Compliant

**Outcome 10. General Welfare and Development**

*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Residents had the opportunities for general welfare and development through the attendance of day services.

Residents attended day services and some residents had retired from their day services or had personal assistance.

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

**Findings:**
Improvements were required to ensure residents assessed healthcare needs were met.

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. The inspector viewed six healthcare plans and found some of these required improvement to ensure medical treatment recommended for residents were implemented and healthcare needs were met. Areas identified included:
- interventions outlined within some residents plans were not accurate. For example, the inspector viewed a plan in place in relation to sleeping, interventions were outlined in relation to discouraging the resident from sleeping during the day. On viewing the 24 hour sleep chart and speaking with staff members the inspector was informed the resident did not sleep during the day. The inspector asked why this plan was in place and was informed this was a healthcare issue when the resident resided in another location, however, this was not a current assessed need. Therefore, the healthcare plan was not updated to reflect the current assessed need of the resident nor were the interventions within the plan evaluated in relation to the effectiveness of the treatment provided

- the management of healthcare conditions, such as, weight management interventions outlined within resident's plans were not evident and other interventions such as, a food diary was identified for one week in June, however, on the day of inspection this remained on going without any rationale

- some other healthcare plans viewed were not updated to reflect practice as the interventions specified had taken place, therefore, plans were not reviewed in accordance to the changes to the resident's needs

- the review process in place for healthcare 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

- evidence that some healthcare recommendations were implemented were not evident, for example a resident was recommended a bone density scan in 2016 and this had not been completed to date.

The inspector viewed plans which were in place to guide members of staff in the area of epilepsy management and the administration of rescue medication as prescribed.

Residents requiring modification to the texture of their food had this information outlined in the residents' files. The inspector viewed FEDS (feeding eating drinking swallowing) guidelines in place for some residents. Over the course of the day the inspector observed staff members implementing the individual intervention specified with individual residents.

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

**Judgment:**
Non Compliant - Moderate

**Outcome 12. Medication Management**
*Each resident is protected by the designated centres policies and procedures for medication management.*
Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Medication management within the centre required significant improvement to ensure suitable practices relating to the storing, disposal and administration of medication.

The inspector found some PRN (a medicine only taken as the need arises) medicine did not have the maximum dosage stated for a 24 hour period.

Staff members were not clearly guided in the administration of some PRN medicine. For example, a resident was prescribed more than one medication for pain relief. There was no guidance available to staff members when to administer what medication or if both medications could be administered.

One PRN medicine did not have the name of the resident contained on the medication.

For one resident PRN medicine was not available within the centre on the day of inspection.

The inspector viewed the administration sheets and the stock balance recording chart and found inaccuracies as the stock balance recorded less medication than what was recorded as administered to the resident. Staff members could not account for this medication nor was there a medication error form completed for this incident when the inspector requested to view this document.

The inspector acknowledged there was a system in place for recording, reporting errors and reviewing medication. The inspector viewed incidents which occurred within the designated centre, and found evidence of learning from some of these incidents to mitigate the risk of future reoccurrences.

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

Medication was supplied to the designated centre from the organisations based pharmacy, medication was recorded when received.

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

**Findings:**
The details contained within the statement of purpose in relation to the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 was not reflective of practice within the centre. Areas included:

- the number, age range and gender of the residents for whom it is intended that accommodation should be provided

- the total staffing complement, in full-time equivalents, for the designated centre with the management and staffing complements as required in Regulation 14 and 15

- the arrangements made for dealing with reviews of resident's individualised personal plan.

**Judgment:**
Substantially Compliant

### Outcome 14: Governance and Management

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

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
Significant improvements were required in the area of oversight of this centre to ensure safe, consistent and effective delivery of care in accordance with residents' needs. This was evident through the findings of this inspection within the outcomes inspected and the significant level of non-compliances identified.

The inspector found the management structure in place did not have clear lines of authority, roles and accountability among the layers of management within the designated centre. Therefore, the management of the designated centre did not ensure the quality and safety of the provision of services in a consistent manner to the residents within the centre.

For this centre the person in charge was supernumerary to the rota and was supported by two clinical nurse one managers who were also supernumerary. Both the person in charge and the clinical nurse manager ones reported to a clinical nurse manager three who was also supernumerary. The inspector requested to view evidence of collaboration and meetings taking place in relation to the management of this centre, however, the inspector was informed that meetings took place without minutes.

The inspector viewed minutes of staff meetings within the designated centre, however, these were not conducted regularly and were completed within each house. No staff meetings took place from a centre based perspective despite staff moving from house to house. In a number of staff meeting records viewed resident needs were the only topic discussed and members of management were not present within staff meetings on a regular occurrence.

The inspector found the monitoring of the service provided was not effective as audits in relation to medication and residents finance were limited. Where audits did occur they failed to identify some basic fundamental findings which the inspector identified during this inspection. For example, action from a previous medication audit, completed in one house, was not followed up on. In addition the inspector requested to view previous audits completed these could not be retrieved on he day of inspection. Therefore, the inspector identified the practice of auditing was not leading to an enhanced quality of life of residents or bring about improvements in practice as there was minimal learning evident.

In relation to, the quality of service delivered to residents no audits had been completed in relation to health and social care. For example, the inspector viewed minutes of a team meeting held January 2017 for one house, this identified the need for staff to complete social plans with residents. Staff were also given the templates to follow through on this at this meeting. However, the inspector found social care plans were not in place or up-to-date for most residents. The inspector requested the follow up completed by management to ensure the social care plans were devised and implemented, however, this was not available.

Effective arrangements to support, develop and performance manage all members of the workforce was not occurring within the centre. The centre had a yearly performance appraisal system in place, yet, this was not being implemented effectively. The inspector
viewed a sample of five staff members' performance appraisals. One of the staff member's record identified an appraisal was completed in 2017, the other four members of staff had no record present for 2017. The inspector identified this did not facilitate staff members to exercise their personal and professional responsibility for the quality and safety of service they provided within the centre.

The provider had carried out an unannounced visit on a six monthly-basis in 2017 to the four houses in this centre this was dated 28 June 2017. An action plan was developed with timeframes and people to carry out these actions. There was also an annual review in place for the designated centre dated 2016.

**Judgment:**
Non Compliant - Major

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

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

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The provider nominee outlined suitable arrangements would be made if the person in charge was absent from the centre in accordance with the specified timeframes.

**Judgment:**
Compliant

### Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

**Theme:**
Use of Resources

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The centre was resourced in terms of staff numbers in accordance with the centre’s statement of purpose.

**Judgment:**
Compliant

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

**Theme:**
Responsive Workforce

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

**Findings:**
Overall, the inspector found significant improvements were required to ensure continuity of care to residents and ensure negative outcomes for residents were not occurring due to lack of regular familiar staff members.

The inspector viewed the proposed and actual staff rota and found the centre was heavily reliant on relief and agency staff members. This was further compounded by the fact that one resident displayed 79 incidents of self injurious behaviour over a three month period and this was documented as being associated with a transition and unfamiliar staff.

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

The inspector found that staff resources were not organised in a way to meet the assessed needs of residents. For example, on the second day of inspection the staff numbers in the morning of the inspection were three staff members in one house for a period of time when there was no residents present. From viewing the rota within this house and speaking with members of staff this house required additional staff members at times. Therefore, the inspector found staff members were not allocated to meet residents’ needs and one house where resident’s diagnosis required structure and familiarity was excessively reliant on relief staff members.

The inspector requested to view a sample of staff members’ supervision, out of a sample of five staff members files viewed one staff had received supervision in 2017. The inspector also requested to view a sample of the core relief staff members supervision.
The person in charge identified these staff members were not supervised from within
the centre as a separate department completed this. The inspector found the system in
place for supervision required review to ensure all staff members were appropriately
supervised in their role within the centre. Some members of staff spoken with identified
they had not received supervision.

From viewing 37 members of staff training records, six members of staff required
training in the area of the management of behaviour that is challenging including de-
estalation and intervention techniques and two members required refresher training.
Two members of staff required refresher training in the area of the prevention,
detection and response to abuse and five members of staff required refresher training in
the area of fire.

Another inspector reviewed a sample of staff files for the organisation on a separate day
to the inspection and found some of the information required by Schedule 2 of the
Regulations were not present in staff files such as, a volunteer agreement.

Judgment:
Non Compliant - Major

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:
Improvements had occurred in relation to records and documents since the previous
inspection.

Schedule 5 policies for the centre had been submitted into HIQA before this inspection.
The admissions policy present within the designated centre was not the up-to-date
policy available within the organization.

Overall, the inspector found the retrieval of some schedule 3 documents was difficult,
and in some instances, documents were unavailable, out of date or blank within
residents’ files. Duplication existed across residents’ files in several incidences for example, the inspector viewed a plan of care in relation to intimate care this stated staff to read and implement my intimate care plan. The inspector identified this was not a plan of care and was subsequently provided with another document in relation to intimate care.

**Judgment:**
Non Compliant - Moderate

### Closing the Visit

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

**Acknowledgements**

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

**Report Compiled by:**

Karina O'Sullivan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

Centre name: A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID: OSV-0004925
Date of Inspection: 12 & 13 October 2017
Date of response: 12 December 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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Evidence that each resident’s privacy and dignity was respected in relation to, their personal and living space for example, the process of night checks occurred without a rationale.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 09 (3) you are required to: Ensure that each resident’s privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
The PIC is collaborating with the night supervisor and house staff to assess and discuss the need for night time checks and ensure that these are carried out based on the needs of the individual and not as general practice. This information will be then documented in the individual’s personal plan within the appropriate section.

**Proposed Timescale:** 30/01/2018

**Theme:** Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Evidence was not available that each resident, in accordance with their wishes and disability, participated in and consented, to decisions about the use of their finances and decisions in relation to their home.

Residents meetings were limited within some houses.

2. **Action Required:**
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
• The costs incurred by individuals for prescribed medical products, food items and car parking has been refunded to the individuals affected. Copy of Appendix 1, memorandum of understanding/contract of Care has been placed in each individual’s financial ledger to ensure staffs are aware and have a clear understanding of costs covered by Cheeverstown House. To protect the rights of the individual and aim for compliance with Outcome 01.
• Meetings will be held with staff to discuss the financial policy currently in place, and ensure staff understand and sign same commencing 09/12/17
• A new format for residents meetings/consultation will be established. This will take into account the varying level of communication supports required for residents to ensure meaningful engagement to establish preferences and choices in house activities.
• This will be completed with the assistance of OT and SLT for each house based on the needs and preference of the individuals residing the house.

**Proposed Timescale:** 30/01/2018

**Theme:** Individualised Supports and Care
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Complaints were not investigated, at all times, in a timely manner.

3. Action Required:
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

Please state the actions you have taken or are planning to take:
All complaints will be recorded, documented and investigated in a timely manner by PIC or her delegate.

Proposed Timescale: 29/12/2017

Outcome 02: Communication
Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Resident's did not have access to the internet within their homes in the centre.

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

Please state the actions you have taken or are planning to take:
Residents do have access to internet in their home; however, funding has been secured by Cheeverstown to upgrade to Wi-Fi.
The IT department is currently phasing in access to WIFI within the campus and the people who have indicated a preference for access will be prioritised.

Proposed Timescale: 29/01/2018

Outcome 03: Family and personal relationships and links with the community
Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Supports to develop and maintain personal relationships and links with the wider community in accordance with resident's wishes were limited.

5. Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to
develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
Social care plans for each individual are currently being reviewed in conjunction with the individual in so far as they are willing to participate and where required are being commenced.
Eight staff has attended training in relation to “My Life” plans to ensure that person centered meaningful activities are identified. Remaining staff are scheduled to attend in early 2018

Proposed Timescale: 30/01/2018

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
From the sample of residents' files viewed one resident did not have a written agreement in place.

6. **Action Required:**
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
A copy of the agreed financial assessment will be included within each persons file.

Proposed Timescale: 29/12/2017

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some written agreements were not up-to-date to reflect the provision of services including the support, care and welfare of the resident and details of the services to be provided for that resident and the current fees and additional charges.

7. **Action Required:**
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
Financial assessments have been completed for each individual. DC2 are currently collaborating with the finance department to draw up contracts which will indicate the provision of services based on assessed need. Copy of Appendix 1, memorandum of understanding/contract of Care has been placed in each individual’s financial ledger to ensure staff are aware and have a clear understanding of costs covered by Cheeverstown House.

**Proposed Timescale:** 30/01/2018

### 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:

From the sample of residents' personal plans viewed it was not evident that these were reviewed annually or more frequently if there was a change in needs or circumstances for residents.

**9. Action Required:**

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.
Please state the actions you have taken or are planning to take:
All individual plans will be reviewed on an annual basis. The PIC has issued a schedule for reviews and will monitor same.
Guidance will be given to staff from the CNM1 associated with each house in relation to conducting effective reviews of personal care plans.

Proposed Timescale: 30/03/2018
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
From the sample of residents plans' viewed reviews did not assess the effectiveness of each plan and take into account changes in circumstances and new developments.

10. 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:
Guidance has been issued for staff to guide practise when reviewing personal plans to ensure the review process assesses the effectiveness of the plans. CNM1’s are present within the houses to monitor and support staff on this process.

Proposed Timescale: 30/03/2018
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not evident that each personal plan was amended in accordance with any changes recommended following a review.

11. 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:
Guidance, supervision and support is being provided to staff from the CNM1 associated with each house in relation to conducting effective reviews of personal care plans. All reviews will consider recommendations for action.

Proposed Timescale: 30/03/2018
### Outcome 07: Health and Safety and Risk Management

**Theme:** Effective Services

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

The system in place in the designated centre for the assessment, management and ongoing review of risk from a centres and individual perspective including a system for responding to emergencies required review to ensure this reflected actual practice.

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

**Please state the actions you have taken or are planning to take:**
To ensure clarity following a fire drill the design of the fire drill report form was amended on the day of inspection to include an area to record the names of residents that take part in the drill.
Fire evacuation plans will be updated and communicated with staff to indicate responses for different scenarios i.e. evacuation response when conducting a drill and evacuation response to a real event.
A reminder has been placed in each house diary for 2018, requesting staff to complete a review of the house risk register and ensuring that same information is reflected in the individual risk assessments and safety plans as weekly task. The PIC and CNM1 will monitor these reviews and organise quarterly meetings with the Risk Manager for review of the effectiveness of plans to minimise the current risks.

**Proposed Timescale:** 30/03/2018

**Theme:** Effective Services

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Adequate arrangements for containing fires were not evident.

13. **Action Required:**
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**
Slattery Fire Consultants will attend in Cheeverstown on 13th December 2017 to work with the Health and Safety officer in Cheeverstown to review DC2 fire containment arrangements in one location. The plan will be revised based on their recommendations to reflect the works completed in the house since the previous inspection including the inclusion of an extra emergency exit and the fitting of fire doors throughout the house.
Proposed Timescale: 20/12/2017

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Evidence that adequate arrangements were in place for evacuating all residents in the designated centre and bringing them to safe locations was not available on the day of inspection.

14. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
The approved fire/emergency evacuation plan is current and up to date and is available within the house.

Proposed Timescale: 12/12/2017

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:
Every effort to identify and alleviate the cause of residents' behaviours were not evident.

Evidence that all alternative measures were considered before a restrictive procedure was used was not available.

Evidence that the least restrictive procedure, for the shortest duration necessary was used was not available.

15. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
Each person will have a MDT assessment to ascertain and document What causes distress, How I communicate my distress and How to manage my distress. This information will be available in the persons plan.
All interventions will be documented on critical incident forms and narrative notes. Staff will receive refresher training on the interventions to ensure good practice on documenting same.
Proposed Timescale: 28/02/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some behaviour support plans did not ensure that staff had up-to-date knowledge appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

Please state the actions you have taken or are planning to take:
PIC will organise a multidisciplinary review of individuals behaviour support plans to ensure that the appropriate information is included to guide staff practice in supporting the person to manage their behaviour. Plans will be updated following each review.

Proposed Timescale: 20/03/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some restrictive procedures including physical and chemical restraint were not applied in accordance with evidence based practice.

17. 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:
All restrictive procedures will be reviewed to ensure that they are applied in accordance with Cheeverstown policy and evidence based practice. Any restriction will be based on the assessed needs of the resident with an overall aim to reduce the restriction over time. Each restrictive practise will be referred to the Rights Review Committee for examination to ensure due process is applied in each individual case. The next medication review in DC2 will include a PRN review of medication in conjunction with the pharmacist.

Proposed Timescale: 28/02/2018
Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse was not in place for volunteers.

18. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
Volunteers undertake separate safeguarding training to that of paid employees, the volunteer had completed safe practice training previously and will attend a refresher training session organised for 20/January/2018 with Cheeverstown Designated Officer.

Proposed Timescale: 20/01/2018

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Effective control measures were not in place to ensure residents were protected from financial abuse.

19. 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:
Copy of Appendix 1, memorandum of understanding/contract of Care has been placed in each individual’s financial ledger to ensure staff are aware and have a clear understanding of costs covered by Cheeverstown House. To protect the rights of the individual and aim for compliance with Outcome 01.
Meetings have commenced with staff to discuss the financial policy currently in place, and ensure staff understand and sign same.
Safeguarding training for staff identifies finance as a category of abuse. Any confirmed incidents of financial abuse will automatically be reported to the authorities including the guards.

Proposed Timescale: 30/01/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement
in the following respect:
Some medical treatment recommended for residents was not evident such as a bone
density scan which was outstanding for a resident since 2016.

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

Please state the actions you have taken or are planning to take:
The bone density scan mentioned above was carried out on 15/11/2017.
Staff in DC2 will ensure all medical recommendations are facilitated.

Proposed Timescale: 28/02/2018
Theme: Health and Development

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

The review process in place for identified healthcare needs required improvement to
identify the effectiveness of the interventions implemented to ensure these had an
positive outcome for residents.

21. 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:
Each person's health care needs will be reviewed and reassessed to ensure the
appropriate supports are in place.

Proposed Timescale: 28/02/2018

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 did not have the maximum dosage stated for a 24 hour period.

Staff members were not clearly guided in the administration of some PRN medicine.

One PRN medicine did not have the name of the resident contained on the medication.
For one resident PRN medicine was not available within the centre on the day of inspection.

Inaccuracies were present within the stock balance of medication.

22. **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:**
A audit of psychotropic and anti anxiety PRN medication has been completed for five people in DC2. The outcome has resulted in discontinuation of some prn medication based on the current assessed needs of the individuals.
A maximum dosage and frequency of dispensing review will be completed for each individual within the designated centre to ensure all prescriptions are appropriate and written in such a manner as to guide staff practice on administration.
Documentation relating to stock balance checks has been reviewed and updated and is monitored by the PIC and Pharmacist on a monthly basis. One person in DC2 has a prescription for a Schedule 2 drug. The procedure for twice daily stock check and two staff administration is in place in this location for the person.

**Proposed Timescale:** 15/02/2018

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The details contained within the statement of purpose in relation to the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 was not reflective of practice within the centre as outlined within the main body.

23. **Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
A full review of the statement of purpose in line with the new guidance document will be completed to ensure it reflects practise in DC2.
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**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:**

Effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services they delivered was not evident.

**24. Action Required:**

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

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

A schedule for the completion of annual performance managements to be completed before the end of year has been devised and is ongoing at present,
As of the 03/12/17 there is 16 of 24 completed, 6 to be completed, 4 cannot be completed due to maternity leave and long term illness.
A schedule for 2018 will be implemented

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**Theme:** Leadership, Governance and Management

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

The management systems in place in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

**25. Action Required:**

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

The PIC for DC2 is supernumerary to the roster. The PIC is supported by two fulltime CNM1’s.
The CNM1’s are assigned on the manager’s roster with specific responsibility for two locations each. CNM1s have specific roles to that nominated house(s).
A copy of this roster is placed in each house. The CNM1’s are responsible for effective supervision of staff.
The roster is currently being revised to ensure compliance on an effective management system that will ensure the delivery of safe and effective service, appropriate to
resident's needs and ensuring these responses are correctly monitored. This will include recommendations and follow up actions for learning based on the results of audit’s completed.

The defined management structure and roles & responsibilities will be given to all staff of DC2.

CNMs will agree a schedule of PDPs for staff allocated to them by the PIC for 2018 Personal Development Plans will be based on the roles & responsibilities of the staff grade and delegated responsibility to them relevant to their role.

CNMs will be held accountable for the completion of staff PDPs

Minutes will be recorded at all meetings between PIC, CNM’s and staff

**Proposed Timescale:** 09/02/2018

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<td><strong>Theme:</strong> Responsive Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Some of the information required by Schedule 2 of the Regulations were not present in staff files such as, a volunteer agreement.

**26. Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

The volunteer agreement which was in place since 06/01/2014 had been archived but has since been retrieved and placed in the individuals file.

All staff, including volunteer staff files have been audited for schedule 2 documents and the outstanding documentation (two items for one staff) will be on file by 13th December 2017

**Proposed Timescale:** 13/12/2017

**Theme:** Responsive Workforce

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

The number, qualifications and skill mix of staff was not based on the assessed needs of residents.

**27. Action Required:**

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.
Please state the actions you have taken or are planning to take:
Assessment of need has been completed for individuals in two of the four locations within DC2. The other two locations have commenced the assessments.

**Proposed Timescale:** 15/12/2017

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff did not have access to appropriate training, including refresher training, as part of a continuous professional development programme from the sample of files viewed.

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

Two members of staff required refresher training in the area of the prevention, detection and response to abuse.

Five members of staff required refresher training in the area of fire.

**28. Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
All staff with training requirements outstanding have been contacted with the exception of those on long term illness or maternity leave and arrangements are being made to ensure compliance.
Two staff attended MAPA training on 07/12/2017
One staff is scheduled to attend Safeguarding training on December 14th.
Four staff attended Fire Training on 04/12/2017
The remaining staff have been booked to attend the next available dates in training scheduled for early 2018.

**Proposed Timescale:** 30/01/2018

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff members were not appropriately supervised.

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

**Please state the actions you have taken or are planning to take:**
CNM1’s have been allocated to houses and are assigned on the roster to ensure supervision for staff.

**Proposed Timescale:** 12/12/2017

<table>
<thead>
<tr>
<th><strong>Outcome 18: Records and documentation</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Use of Information</td>
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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The revised admissions policy was not available within the designated centre.

30. **Action Required:**
Under Regulation 04 (2) you are required to: Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

**Please state the actions you have taken or are planning to take:**
All schedule 5 policies are available in each location

**Proposed Timescale:** 12/12/2017

| **Theme:** Use of Information            |

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The retrieval of some schedule 3 documents was difficult, and in some instances, documents were unavailable, out of date or blank within residents' files.

31. **Action Required:**
Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

**Please state the actions you have taken or are planning to take:**
Resident’s files will be audited with the assistance of night staff to ensure the information required under schedule 3 is present and available.

**Proposed Timescale:** 10/01/2018