<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Centre 3 - Cheeverstown House Residential Services (Active Age/Senior Citizens)</th>
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<td>Centre ID:</td>
<td>OSV-0004926</td>
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<td>Registered provider:</td>
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<tr>
<td>Lead inspector:</td>
<td>Maureen Burns Rees</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Michael Keating</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

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

From: 03 July 2018 09:30  
To: 03 July 2018 17:00  
03 July 2018 09:30  
03 July 2018 17:00  
04 July 2018 10:00  
04 July 2018 16:00

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

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<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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**Summary of findings from this inspection**

Background to the inspection:
This centre 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 a number of centres on the providers campus. The provider was required to submit an urgent action plan and assurance plan in respect of each of non compliances identified. This centre was one of three centres which had not had a registration decision made to date. It is proposed that a registration decision will be made at the end of the regulatory process for each of these centres. This centre was last inspected in January 2018 and as part of this inspection the inspectors followed up on actions from the last inspection.

How we gathered our evidence:
As part of the inspection, the inspector met with the person in charge, two clinical nurse managers, the head of care, the chief executive officer, eight staff nurses, six care assistants, a house keeper, the finance officer and an occupational therapist. The centre comprised of four separate houses. Residents were met with, in each of the houses. The inspector met with 16 of the 21 residents living in the centre.
Residents spoken with outlined that they enjoyed living in the centre. Other residents were unable to convey to the inspectors their views of the service but all of the residents were observed to be in good spirits and to have warm interactions with the person in charge, clinical nurse managers and staff caring for them. The inspectors reviewed care practices and documentation such as care plans, medical records, accident logs, staff files, policies and procedures and daily records.

Description of the service:
The designated centre consisted of four houses which were located on a campus containing a number of residential and day services operated by the provider. Each of the houses provided full-time residential care for adults over the age of 18 years. Two of the houses accommodated seven residents each whilst a third house accommodated six residents. The remaining house had one resident. The service provided was described in the provider's statement of purpose, dated June 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 houses had a number of communal garden areas within the campus with a number of the houses also having an allocated back garden area.

Overall judgment of our findings:
Overall, the inspectors 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 improve the oversight of service delivery. 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 to quality check those actions marked as complete on the urgent action plan.

The acting person in charge had been in the post for over nine months and demonstrated adequate knowledge and competence during the inspection. The inspectors were 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:
- Residents rights, dignity and privacy were found to be upheld. (Outcome 1)
- There were arrangements in place to promote and protect the health and safety of residents and staff. (Outcome 7)
- Arrangements were in place to support residents on an individual basis to achieve and enjoy the best possible health. (Outcome 11)

Areas for improvement were identified in areas such as:
- The regulatory requirement to have an agreed written contract which dealt with the support care and welfare of the resident, including the fees payable was not being fully complied with. (Outcome 4)
- Improvements were required to ensure that meaningful goals and activities were established for some of the residents, that the effectiveness of plans were reviewed, and that residents family representatives and members of the multidisciplinary team were involved in the reviews of personal plans put in place. (Outcome 5).
- Compatibility issues in three of the houses were impacting upon the quality of life
of residents in those houses. (Outcome 8)
- The inspectors were not assured regarding the effectiveness of some of the audits or the management and oversight arrangements, particularly relating to medication management. (Outcome 14)
- There remained a small number of staff vacancies and formal supervision arrangements for staff were in the early stages of being rolled out. (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 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Residents rights, dignity and privacy were found to be upheld.

Residents were consulted with and participated in decisions about their care and support and the organisation of each of the houses. Each of the residents had their own bedroom and their privacy and dignity was observed to be respected by staff. During the previous inspection, the inspector identified that some residents did not retain control of their clothes. On this inspection, resident’s clothing were all found to be laundered separately from other residents and appropriately stored in their individual bedrooms.

At the time of the last inspection, it was identified that a resident did not retain control over their personal possessions in relation to a vehicle purchased. Since that inspection, a contractual agreement had also been put in place and agreed with a resident regarding the use of the vehicle they had personally purchased. Staff spoken with outlined that the resident who owned the vehicle was always given priority usage and that their consent was sought before the car would be used by any other resident. Records of usage were maintained.

There were appropriate arrangements in place for the management of complaints and complaints were found to have been responded to promptly.

Judgment:
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 admissions which outlined the arrangements in place for admitting and transferring residents within the centre. However, the regulatory requirement to have an agreed written contract which dealt with the support care and welfare of the resident, including the fees payable was not being fully complied with.

At the time of the last inspection, it was identified that written agreements were not up to date, to reflect the provision of services including the support, care and welfare of the resident. On this inspection, the inspector found that contracts had been revised to clearly list the services provided and fees payable. However, In one of the residents contracts reviewed, the fees stated were not correct and this was confirmed by the finance manager. It was reported that all revised contracts had been sent out to residents family representatives for review and signing. However, at the time of inspection, a signed copy of the contract was not available on a number of the residents files.

**Judgment:**

Substantially Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

**Findings:**
Overall, 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 to ensure that meaningful goals and activities were established for some of the residents, that the effectiveness of plans were reviewed, and that residents family representatives and members of the multidisciplinary team 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 recently introduced 'my life plan'. Plans in place detailed the individual needs and choices of residents but it was not always clear if the resident or their 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. It was noted that goals set for some residents were limited and could have been more meaningful and appropriate to the individual resident's capacity and interests.

There was evidence that personal plans had been reviewed within the last year. However, some reviews undertaken did not assess the overall effectiveness of the plans and did not involve the residents family or representative. Multi-disciplinary team meetings for individual residents had been undertaken in March 2018 and the minutes from these minutes stated that revisions had been agreed to individual personal plans. However, there was no record made of what the revisions were or if they had been made. Overall, the effectiveness of the plan in place did not appear to be reviewed as part of these meetings.

The inspectors reviewed records of 'my weekly plans' for individual residents which showed that residents were engaged in some activities in the local community and inside the centre. Although it was acknowledged that this had improved since the last inspection, the inspectors considered that a number of the residents could have been involved in a greater range of activities. Visual timetables had been put in place for residents regarding their daily planners.

**Judgment:**
Non Compliant - Moderate

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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):
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. Training records showed that staff had attended fire safety training. At the time of the last inspection non compliances were identified in relation to the arrangements for containing fires. These non compliances were found to have been suitably addressed on this inspection. 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. 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.

There was a risk management policy in place, dated April 2015, which was in the process of being reviewed at the time of inspection. At the time of the last inspection, the system in place for the assessment, management and on-going review of risk, including the system for responding to emergencies was identified to require improvement. On this inspection the inspectors found that 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 emergencies. 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. All areas were observed to be clean and tidy but there was a small amount of chipped paint on walls and woodwork in a number of the houses which could hinder the effective cleaning
of these areas. 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. At the time of the last inspection, infection prevention and control measures were not found to be effectively implemented in relation to personal protection equipment and the management of sharps. On this inspection, these issues were found to have been appropriately addressed.

**Judgment:**
Compliant

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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

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

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

**Findings:**
There were measures in place to safeguard residents. However, compatibility issues in three of the houses were impacting upon the quality of life of residents in these houses.

There was a safeguarding policy, dated April 2018, 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. 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 March 2017. At the time of the last inspection, it was identified that some behavioural support plans did not provide sufficient detail to guide staff practice. Since that inspection, all behaviour support plans had been reviewed and revised with input from psychology, clinical nurse
specialist and the staff team. A sample of behaviour support plans reviewed were found to provide sufficient detail to guide staff in meeting the needs of residents identified to require such support. 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 evidence that efforts were made to identify and alleviate the causes of residents' specific behaviours. However, compatibility issues in three of the houses were impacting upon the quality of life of residents. There was evidence that the provider had put some measures in place to support each of the residents. Behaviour support plans which detailed specific cues to assist staff to support individual residents where observed to be followed by staff and to have a positive affect for the resident. There was evidence that transition plans were in place for one of the residents, to move to a more suitable centre which would better meet their needs. Consideration was also being given for a move for two other residents.

There was a policy and procedure on restrictive practices, dated October 2016. At the time of the last inspection, it was identified that some chemical and environmental restrictions used, were not applied in accordance with evidence based practices. On this inspection the inspector found that restrictive practices in place were approved and reviewed by the provider's behaviour support team and the rights review committee. There was evidence that all alternatives were used before a restrictive practice would be used and that the least restrictive procedure for the shortest duration necessary was used. There was a restrictive practice log maintained. Risk assessments had been completed for restrictive practices in place.

The centre had an intimate care policy, dated October 2014. 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:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
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 24/7 within the campus. A general practitioner (GP) was based on the campus two days per week. Each of the residents had their own GP and access to an out-of-hours doctors service. Residents had access to a number of other therapeutic supports. These included: speech and language therapy, dietician, occupational therapy, physiotherapy and clinical nurse specialists. Records were maintained of all contact with GPs and other health professionals.

At the time of the last inspection, the inspector had found that appropriate healthcare to meet some residents assessed needs was not being provided with medical treatments recommended not facilitated, and that staff members had not received training in the required areas. On this inspection, and of the sample of files reviewed, it was found that a comprehensive health assessment had been undertaken with health plans put in place to meet residents assessed needs. These plans were being implemented and all recommended treatments had been provided. Staff had received appropriate training were required.

Residents dietary needs were being met. There was a food, nutrition and hydration policy, dated October 2016. The inspectors observed that a healthy diet and lifestyle was promoted in the centre. There were arrangements in place for residents to be involved in choosing and assisting to prepare meals in individual houses. A food and drink diary was recorded for individual residents and showed that a varied and nutritious diet was provided for residents. Specific meal plans had been put in place, for residents with specific dietary and or health requirements. 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. Each of the houses had a fully equipped kitchen and a dining area, with adequate seating to allow meal times to be a social occasion.

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

Findings:
Although, overall the majority of residents were protected by the centres policies and procedures for medication management, the arrangements in place for the management of controlled drugs were not adequate.

A small number of controlled drugs had been appropriately prescribed for use in the centre. However, the inspectors found that the providers policies and procedures for the administration and management of controlled drugs were not being adhered to. Over an extended period, it was identified that controlled drugs were not being administered at the times they were prescribed. Administration sheets showed staff signatures at prepopulated times, which correlated with the prescribed times, indicating medication administration at these times. However, this time did not correlate with the time recorded in the controls drug register which was an indication of the time medications were removed from the controlled drugs press. On occasions these times were up to two and a half hours later than the prescribed time. No other records were maintained as to a reason for a change or a delay in the administration time from the prescribed time. Staff reported that the medications were given at a time which suited the residents routine but acknowledged that this was not appropriately prescribed or recorded. In addition, on the day of inspection it was identified that in the previous week a controlled drug had been recorded on the administration record as having been administered. However, no record of same had been made in the controlled drug register. This medication omission had not been identified by staff and was discovered by the inspectors.

There was a policy and procedure on medication management and administration, dated April 2015. A secure storage press was in place in each of the houses. 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 for regular medications and found that they had been appropriately completed and were regularly reviewed by the residents general practitioner (GP). 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. A pharmacist was available on the campus three days per week.

At the time of the last inspection it was identified that some PRN or as required medication, did not have a maximum dosage stated for a 24 hour period. On this inspection, the inspector found that all PRN medications had been appropriately prescribed with a maximum dose stated and that protocols were in place for residents who were identified as requiring these.

Judgment:
Non Compliant - Major

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
Arrangements in place to monitor the quality and safety of care and support in the centre had improved since the last inspection. However, the inspectors were not assured regarding the effectiveness of some of the audits or the management and oversight arrangements, particularly relating to medication management.

There was a management structure in place. The acting 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. There was a manager available 24/7 on the campus for support. An electronic roster system had been introduced since the last inspection. Lead staff member on each shift were clearly indicated on the rosters reviewed on this inspection. There were regular staff meetings held in each of the individual houses which were attended by staff from the specific house and the clinical nurse manager who oversaw the house. These informed centre meetings which were held on a monthly basis and attended by the person in charge, clinical nurse managers and staff from each of the four houses.

The person in charge held a full-time position but was in an acting position pending the recruitment of a suitable full time person in charge. She was not responsible for any other centre and was supported by two clinical nurse managers. The acting person in charge had been manager in the centre for more than nine months and before that she had been working as a senior manager in the service for more than 10 years. She was a registered nurse in intellectual disabilities and held a degree in nursing. The inspectors 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. Formal supervision arrangements were in the process of being rolled out across the centre and the person in charge had received supervision from her line manager and had in turn provided formal supervision to a sample of the staff team.

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. At the time of the last inspection, the management systems in place did not ensure that the service provided was safe, consistent and effectively monitored. Since that inspection, a schedule of walk-arounds 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
An annual review of the quality and safety of care as required by the regulations had been completed. Unannounced visits to the centre on a six monthly basis, as per the requirements of the regulations had been undertaken.

A number of audits had been undertaken in the centre as part of an audit cycle. These included audits of 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. However, the inspectors were not assured of the effectiveness of a number of these audits, in particular those relating to medication management. As referred to under outcome 12, non adherences to the providers policy for medication administration and management, specifically relating to controlled drugs, had not been identified through the audit process or through the management and oversight arrangements in the centre.

**Judgment:**
Substantially 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:**
There had been recent staff recruitment and overall the staff numbers and skill-mix were appropriate to meet the assessed needs of residents in the centre. However, there remained a small number of staff vacancies and formal supervision arrangements for staff were in the early stages of being rolled out.

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, an assessment of need had been completed for individual residents and 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. New staff members had recently been recruited to work in the centre. However, the staff complement for the centre remained short by one and a half whole time equivalent staff members. 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 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 policy in place, dated July 2017. There was a training programme in place which was coordinated centrally by the provider. Staff training records reviewed by the inspector showed that staff had attended mandatory and other identified training to meet the needs of the residents.

Overall effective recruitment and selection arrangements were in place. There was a recruitment and selection policy in place, dated January 2017. The inspectors reviewed a sample of six staff files and found that the information as required by schedule 2 of the regulations was in place.

Formal supervision arrangements for staff was in the early stages of being rolled out for staff across the centre. Supervision, which was of a good quality, had recently been completed with a number of the staff team. Supervision dates for the remaining staff members had been scheduled. It was noted that an annual performance review was completed.

**Judgment:**
Substantially Compliant

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Maureen Burns Rees  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<td>03 and 04 July 2018</td>
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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 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:

In one of the residents contracts reviewed, the fees stated were not correct and this was confirmed by the finance manager. A signed copy of the contract was not available on a number of the residents files.

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 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:**
All residents have been financially reassessed on July 5th 2018 under the HSE RSSMAC tool. All individuals have been issued with new contracts of care. All families will receive a copy of the assessment and the contract and are requested to return a signed copy by August 23rd 2018 for individuals who are not in a position to give consent. The PIC in conjunction with the finance department will follow up with families regarding the return of the documentation. An update of this progression will be noted in resident’s file

**Proposed Timescale:** 30/09/2018

**Outcome 05: Social Care Needs**

**Theme: Effective Services**

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was noted that goals set for some residents were limited and could have been more meaningful and appropriate to the individual resident’s capacity and interests.

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

**Please state the actions you have taken or are planning to take:**
The quality department in conjunction with the multidisciplinary team will support the PIC, staff and individuals to identify meaningful goals that reflect their interests and capability. A revised assessment and planning tool will commence with individuals who have type 3 and type 4 communication supports.

**Proposed Timescale:** 02/11/2018

**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 undertaken in March 2018 and the minutes from these minutes stated that revisions had been agreed to individual personal plans. However, there was no record made of what the revisions were or if they had been made. Overall, the effectiveness of the plan in place did not appear to be reviewed as part of these meetings.

3. **Action Required:**
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
A review of the form utilised to capture recommendations and minutes at multidisciplinary reviews is currently being undertaken. The new documentation will capture revisions and the evaluation of the effectiveness of each person’s plans. This form will be used at the DC3 schedule of residents reviews.

50% of residents will have their annual review completed in October, the remaining residents will have their annual review in March

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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence that personal plans had been reviewed within the last year. However, reviews undertaken generally did not involve the residents family or representative.

4. 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 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:
The PIC has organised a schedule of meetings to review each individual’s personal plan. The meetings will include the person, family where appropriate and multidisciplinary team. The reviews will include the monitoring of the effectiveness of the plans in achieving the goals.

50% of residents will have their annual review completed in October, the remaining residents will have their annual review in March

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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence that personal plans had been reviewed within the last year. However, some reviews undertaken did not assess the overall effectiveness of the plans.
5. 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:
1. There are 21 residents in DC3. The PIC will review the personal plans with the DC management team.
2. My Life Plan training includes giving staff guidance on how to review the effectiveness of a plan and all staff employed in DC3 will receive this training.
3. The evaluation form has been revised by the quality department to give clearer guidance to staff which will ensure that all relevant information and topics are covered within the review to measure the effectiveness of the plan.
4. Families will be invited to participate in the review of the resident’s overall personal plan annually.

Proposed Timescale: 31/03/2019

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Compatibility issues in three of the four houses were impacting upon the quality of life of residents.

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

Please state the actions you have taken or are planning to take:
The staff in houses will continue to support residents guided by the Safeguarding Plans, and in line with the Safeguarding Policy.
A transition plan for one resident (currently sharing a house with 6 other people) has commenced, with a view to him moving to the community within 6 months.
Another resident has been assessed by another healthcare provider which may better meet his needs.

The inspection findings in relation to compatibility will be raised at the next Cheeverstown Decongregation Meeting (August / early September).

Proposed Timescale: 31/03/2019

Outcome 12. Medication Management
Theme: Health and Development
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The providers policies and procedures for the administration and management of controlled drugs were not being adhered to.

Over an extended period, it was identified that controlled drugs were not being administered at the time they were prescribed.

On the day of inspection, it was identified that in the previous week a controlled drug had been recorded on the administration record as having been administered. However, no record of same had been made in the controlled drug register. This medication omission had not been identified by staff until it was identified by the inspectors.

7. Action Required:
Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

Please state the actions you have taken or are planning to take:
The MDA medication and error identified was discussed with all staff in the house by the PIC. A Medication Error form was completed.
The persons Kardex has been revised by the pharmacist, PIC and prescriber on 31/07/2018 to ensure the prescribed information is clear and guides staff practice on administration.
Staff administering the MDA medication are now doing so in line with the Cheeverstown Policy.

Proposed Timescale: 10/08/2018

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:
Inspectors were not assured of the effectiveness of a number of these audits, in particular those relating to medication management. As referred to under outcome 12, non adherences to the providers policy for medication administration and management, specifically relating to controlled drugs, had not been identified through the audit process or through the management and oversight arrangements in the centre.

8. 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:
An audit specific to MDAs will commence in DC3 (and on campus). This audit will be done by the PIC (or delegated to a CNM1) monthly. The audit results will be discussed at team meetings.

Proposed Timescale: 31/08/2018

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<th>Outcome 17: Workforce</th>
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<td><strong>Theme:</strong> Responsive Workforce</td>
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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The staff complement for the centre remained short by one and a half whole time equivalent staff members.

9. **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:
There are 1.5 wte vacant positions in DC3. Recruitment efforts to fill these vacancies 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 DC3 to ensure continuity of support.

Proposed Timescale: 31/10/2018

| Theme: Responsive Workforce |

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Formal supervision arrangements for staff was in the early stages of being rolled out for staff across the centre.

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

Please state the actions you have taken or are planning to take:
The schedule for formal supervision and annual performance management meetings with each staff member has commenced. The plan for 2018 is in place and the 2019 plan will propose one formal meeting each quarter to include performance management.
| Proposed Timescale: 31/12/2018 |