Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Ltd
Centre ID:	OSV-0003556
Centre county:	Dublin 6w
Email address:	info@cheeverstown.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Ltd
Provider Nominee:	Brian Gallagher
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
11 June 2014 08:30	11 June 2014 15:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first monitoring inspection of this centre. It took place over 1 day and reviewed 7 of the required outcomes in full to demonstrate compliance with the legislation and regulations. As part of the monitoring inspection the inspector met with residents and staff members. The inspector observed some practices and reviewed the documentation including personal plans, medical records, accident and incident reports, policies procedures and personnel files.

The centre is designated as one of five community based centres managed by Cheeverstown House Ltd for adults with intellectual disability. The accommodation consists of three individual houses in the local community. Care is provided for up to 11 people and one of the houses is designated for five day per week residential care. The houses accommodate both mixed and single gender adults with between five and three residents in each.

The inspector found evidence of a commitment to provide care for residents needs within a multidisciplinary framework while promoting the independence and the safety of the residents and continued involvement in their local communities. There was evidence of inclusion and involvement of residents and or their representatives. There was evidence that resident's diverse healthcare and psychosocial needs were well supported overall and promptly responded to by staff. Access to a range of allied services including psychological and mental health specialists was evident. Integral supportive governance systems included a director of service, person in charge,

clinical director, quality controller, psychological services and operations and environmental management systems. Residents expressed their satisfaction with both their places of residence, the staff care of them and the opportunities they had to have meaningful work and recreation.

During the course of the inspection the inspector noted that a small number of staff from the community houses had not had fire training although all were scheduled to so in September 2014. However, it was also noted that staff that have responsibility for managing the campus and the community houses at night had not had fire training in two years. This was brought to the attention of the provider who acted immediately and arranged training for 13 June 2014, two days after the inspection. Documentary evidence of this was provided to the Authority.

Areas for improvements were found to be required as follows:

- Development of risk management policies
- Development of centre-specific infection control policies
- Complete and detailed documentation of resident's healthcare assessment and outcome of these assessments
- Staffing rostering arrangements in terms of maintaining records and follow up appointments for residents
- Adherence to mandatory training requirements
- Medication management policy and procedures
- End-of-life policy
- Confirmation of compliance with the statuary fire Authority.

The inspector acknowledges that the provider had already commenced work in order to address the actions outlined in this report and achieve compliance.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Effective Services

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

Findings:
All residents, including the residents living in the five day residential house had personal plans in place and there was evidence that these were reviewed consistently and at a minimum annually. The plans contained information based on a range of up to 15 possible outcomes including health, recreation, work, social networks, choice in routines, personal care needs and supports. There was evidence, and this was confirmed by the residents that they participated in these plans and they were implemented in consultation with them.

In most cases the plans reviewed by the inspector were reflective of the assessment and interventions of a range of allied disciplines. For example, dietary requirements or support with mobility, mental health needs and social aspirations. This was not a consistent finding however and in some instances, the reference in the plans was too vague to guide the practice, for example in terms of dietary requirements. It was also difficult to ascertain if the plans and outcomes had actually been achieved.

However, residents were supported to be involved in a range of interesting and meaningful activities and attended either day care services or workshops and some had part time employment. There were communication systems evident between these day services and the centre staff to ensure residents were safe and supported. Residents informed the inspector of their involvement in activities which they said kept them very busy such as bowling and other sports, going out for dinner or to the cinema, on day trips of their choosing and to organised activities including the club in Cheeverstown which was held weekly. The inspector observed that within the houses residents had their own personal recreational items such as televisions, books or exercise machines and had a choice in the decoration and choosing of furniture for their rooms. Family involvement was pivotal and supported and residents had close links with the local

communities in which they lived.

There was evidence observed of day-to-day strategies implemented including help with personal care and preparing meals, and shopping appropriate to the capacity of the resident. Effective communication tools such as "social stories" and pictorial images were used to support residents understanding. A pictorial version of a personal plan was provided to residents in some instances. In another case signing language diagrams were posted on the wall to facilitate communication between residents and staff.

Care in the community was supported by the organisation via a number of networks. This included the holding of "complex needs meetings" for multidisciplinary review and support for the care team and a review by the mental health and intellectual disability team as appropriate. The complex needs team meeting takes place regularly and are attended by the psychological services and family or representatives and allied clinicians involved. Clinical reviews under the supervision of the clinical director also take place. The purpose of these reviews is to review current accommodation arrangements outcomes of treatment plans or medication review and there was consultation with the residents own general practitioner (GP) either directly or via the centre staff.

Transitions between centres were found to be managed in consultation with the residents and with opportunities to meet with other residents.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Some improvements were required in the overall management of environmental risk. There was a signed and current health and safety statement in the centre. A location specific health and safety audit and action plan for each house was in the process of being developed.

The provider had commenced the review of the risk management policy as required following the previous inspection of the organisation but this had not as yet been fully completed. The policy required improvement in order to ensure it specifically addressed the requirements specified by the regulations, the corporate response to risk identification and management and learning from adverse events. A detailed risk register was maintained and this did contain evidence of identification and management

of risk pertaining to accidents and incidents. Incidents were reviewed as they occurred and further audited. These audits indicated that the data was analysed for themes and emerging issues.

There was a policy on the control of infection. However, centre specific guidelines had not as yet been incorporated into the policy with reference to the centres themselves. Staff were familiar with the procedures and could describe hand washing and cleaning procedures to the inspector. In an instance where specific precautions were required for a resident the clinician responsible had provided very specific guidelines and were able to inform the inspector of this procedure. Clinical waste was managed according to guidelines. There was an emergency plan which dealt with breakdowns in heating, water systems and fire safety evacuation procedures. Staff were able to articulate the arrangements for support and interim shelter in other nearby houses or the campus should this be required. Emergency numbers for such events and systems for contacting local emergency services and the management team were also contact able in such an event. There is a dedicated night manager over all of the centres form 21:00hrs each night. Although no generator is available in the event of an electricity outage notifications to the authority in relation to a small number of these incidents indicated they were of short duration. The campus does have a generator and if necessary for medical reasons residents could be facilitated in that location.

Examination of records demonstrated that equipment required for residents safety and comfort including one specialised mattress were serviced by contract and as required. There was evidence that the fleet of vehicles used which is located on the campus was insured and tested for road worthiness.

In practice procedures were safe and indicated that resident's safety was prioritised. Where deemed necessary manual handling plans were in place for residents. Although a falls risk assessment had not been undertaken on a resident there was a definitive plan outlined by the physiotherapy department to prevent such incidents. Staff were aware of the protocol. Assistive equipment such as walking frames and or wheelchairs were available for residents. Policy and procedure in the event of a resident going missing or a system to minimise this risk required amendment however, in order to be centre specific and take account of the location and circumstances of the residents.

The individual houses were observed to be suitable and safe for the residents with suitably adapted and assisted shower rooms and wheelchair accessible entrances and back gardens. However, in one of the houses the garage, accessed via the kitchen held a number of potential risks. These included a foot high step into the garage, gas bottles in full view and broken concrete steps which could pose a risk to the residents.

Records available indicated that between two and three fire drills had taken place in the individual houses since January 2014. The drills were held at various times including night time. Residents were involved in these drills. Improvements were required in the fire safety management systems however. There was evidence that emergency lighting and fire fighting equipment was serviced annually and the fire alarm was serviced quarterly as required. Daily checks on exit doors and the fire alarm panel were undertaken and documented by staff. In one house however, the extinguishers had not been serviced since February 2013 and one of the houses did not have a fire alarm

installed although smoke alarms were in place. Staff used the security alarm to undertake a fire drill. Records indicated that while fire training had taken place for staff in January and February 2014 facilitated by a suitably qualified person, up to six staff working across the community houses had not undertaken this training. The provider is aware that he will be required to provide written evidence of compliance with the statutory fire authority by a competent person in order to achieve registration and to this end has commenced the process of having the individual houses inspected by a competent person.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
The inspector reviewed policies and procedures for the prevention, detection and response to allegations of adult abuse and found that they were satisfactory, clearly set out the responsibilities within the organisation, knowledge of the appropriate personnel in statutory services and reporting mechanisms in this matter. There is a designated officer for both adults and children's services identified. Staff were able to articulate their understanding and responsibility in relation to this.

In recognition of the fact that staff in some houses work primarily alone the inspector was informed that a lone working policy was being developed and would include systems for monitoring staff and residents. It was evident that although the current line managers may not attend at the houses daily there was regular phone contact between staff and these line managers. Individual residents were supported with safety plans, which covered issues such as travel training, recognition of unsafe situations and what to do in an emergency and how to use mobile phones. One of the residents uses a taxi to get to work and the staff had arranged that it is always the same driver to ensure the resident feels safe. Residents told the inspector that they felt safe living in the centre and with the staff. There were good procedural guidelines on the provision of personal care to residents including respecting residents privacy and dignity. Residents were seen to have an understanding of personal space and respecting other resident bedrooms.

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):
No actions were required from the previous inspection.

Findings:
There was evidence that overall residents healthcare needs were supported to a good standard with some improvements required in the management of the documentation and the integration of the interventions prescribed by various allied professions. Residents have a choice of general practitioner (GP) and may if they choose and it is feasible continue to attend the own GP in the community. Visits usually take place in clinics which is appropriate to the capacity and independence of the residents. Staff maintain a record of all appointments although in some instances the outcome is not clearly recorded on this record. Out of hours service is available. Records and interviews demonstrated that there was very regular access to medical practitioners and staff were observant and responsive to any changes in the residents medical status. There was evidence of regular access to opthalmatic services, hearing specialists, and dental and chiropody services available. Referral to and regular consultation with allied services as required by the residents, including physiotherapy, occupational therapist, dietician and speech and language therapy were apparent. These services can be accessed internally and referrals are via the residents GP. Clinical overview by psychiatric and psychological services is available to residents and to staff in an advisory capacity.

In consideration of the type of roster and to ensure that any relief staff are informed of the residents needs, a synopsis of the resident care needs is maintained. While in most cases this was found to be succinct and relevant this was not a consistent finding. For example, the record on health did not detail the most significant and complex healthcare needs for one resident until page 7 of the document and in another the specific dietary needs were not identified at all. This finding is also referenced in Outcome 5 social care needs in the integration of the various interventions in the personal plans for residents. For example, the complex needs team recommendation in 2013 had made recommendations including a referral to a dietician, blood tests and a scan. In two instances these recommendations had not been undertaken and in another it was not clear if they had been implemented. Due to the documentation used there was no composite health assessment and status documentation available. Therefore the records did not provide full information on residents overall health status, changing health status or underlying conditions in some instances which is pertinent to the provision of care. The staff demonstrated knowledge of the healthcare status of the residents in most

instances. However, despite a clear protocol for the management of epilepsy this was not known by staff. A resident was able to clearly inform the inspector of his complex healthcare procedures and staff were very knowledgeable on this process. Despite the complexity of the healthcare needs residents were supported to remain as independent as possible and continue with routines and life plans.

Residents who required modified consistency diets were reviewed by the speech and language therapist and recommendations made relating to their consistency of diet was available to staff. The direction was clear and staff were familiar with the instructions. Routine monitoring of health was undertaken including blood sugars, weight monitoring and blood pressure if this was required.

The policy on supporting residents at end of life was not as yet completed. However, a revised care plan had been developed should this be required. This plan demonstrated that consideration was being given at an appropriate stage to managing the social, emotional spiritual and healthcare needs in a consultative manner. The inspector was informed that where residents preferences are to remain in their home at the centre at the end of their life increased staffing and nursing support would be made available as would access to palliative care support.

The houses in the centre are fully equipped with cooking catering and dining facilities in a very homely and domestic environment. Residents confirmed that, as they wish and according to their capacity they do their own shopping, help staff with shopping and prepare their own meals. They could if they wished have friends over for meals. They prepared daily lunches if they were going out. Menus for the day were posted in suitable locations. Dietary advice and guidance in terms of nutrition and healthy eating was evident.

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:
The current medication management policy was not sufficient to adequately guide practice in accordance with legislation and guidelines and was in the process of being revised. Currently it did not detail requirements such as the use of Pro-re-Nata (as required) medication and the management of controlled medications. There was

evidence that medication was being reviewed regularly by the appropriate practitioner whether mental health or general. A documented system for the return of medication had been introduced. A small number of residents were self administering some medication and an assessment of the suitability of this had been undertaken. Training for staff in medication management was scheduled in order to ensure they were familiar with the revised procedures being introduced which included a revised medication administration sheet and systems for receipt of medication. A sample of medication management charts reviewed did not indicate any incidents or errors. A review of incident records indicated that any which did occur were found to be promptly reported and remedial actions taken. A medication audit was undertaken and any discrepancies were noted and acted upon.

Residents in some instances take their medication in the sealed folder to their day care centres. Staff in the centre then sign the administration record to indicate the medication has been administered. However, there is no communication system via the centre and the day care to ensure the medication had been administered to the resident. Controlled medication was not currently in use but there was a suitable system in place for managing this.

Judgment:
Non Compliant - Minor

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):
No actions were required from the previous inspection.

Findings:
Overall the inspector found that governance arrangements as implemented by the board of management were satisfactory and there was evidence of good governance systems. In order to achieve the stated aims of the organisation the voluntary board had put in place a professional operational management team. This included the nominee of the provider who is engaged full-time as the chief executive officer, and the director of services who is currently nominated as the person in charge. She is suitably qualified and experienced and demonstrated knowledge of the regulatory and legislative requirements and her responsibilities. There are suitable deputising arrangements in place. Regulatory requirements such as the forwarding of statutory notifications to the

Authority have been complied with. The governance team is also comprised of a clinical director, quality assurance manager and operations/environmental manager. The community services which this centre forms part of are also overseen by a clinical nurse manager (CNM) 3 and two CNM2. A social care leader had also been appointed in each house. Reporting structures and levels of accountability were clearly defined and the person in charge was found to be fully aware of and knowledgeable on the practices in the houses and the residents ongoing care needs. Residents were aware of the senior managers and their own local mangers. Advocates from within the resident group are appointed to ensure the governance systems took account of the views and needs of the residents. The provider stated that it is intended to revise the current management arrangements in order to formalise the management functions within the centre. This will involve the appointment of a number of persons to the role of person in charge of the various community services as the process of registration commences. This is to ensure that the management structure can function effectively given the size of the service. On call is undertaken by a night manager who is responsible for the 15 community houses and the campus.

A number of processes are used to monitor and oversee the safety and quality of care. These included the undertaking of three monthly and annual reviews of accidents and incidents from which remedial actions were identified and monitored for compliance. An annual analysis of incidents is also undertaken. There was evidence to demonstrate that the service overall was well managed and focused on development and positive outcomes for residents.

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):
No actions were required from the previous inspection.

Findings:
The inspector was satisfied from observation and rosters, both actual and planned available that both the skill mix and numbers of staff was satisfactory to meet the needs of the residents. Staffing levels and skill mix in each house were driven by the needs of the resident and where fulltime nursing was required this was provided. One of the houses has a nurse on duty due to the health care needs of the residents. Staff sleep

over in each house nightly. An additional staff member is available in the morning time to support residents morning routine where this is required. Additional resource staff are allocated for specific periods for instance, a number of days per week to ensure residents activities, recreation or appointments can be facilitated. Agency and a small number of consistent relief staff are used to supplement the staff quota. In recognition of the primarily social model of care utilised the houses are led by social care leaders.

As the residents are out during the day in most cases the house are not staffed until circa 15:00hrs in the afternoon. The inspector found and staff confirmed that this leaves little opportunity to follow up on resident's personal places or other in some instance appointments. This in effect may account for some of the findings in terms of follow up for appointments and in documentation described in both Outcome 5 Social Care Needs and Outcome 11 Healthcare.

The inspector reviewed the personal records for five staff of various grade and roles and found there was substantial compliance with the requirements including two references, Garda Síochána vetting, and evidence of qualifications and photographic identification. Files had been reviewed and missing documentation noted previously was in the process of being sourced. The files were found to be in good order with documentation easy to access. There was evidence of registration with the professional body where this was required. Volunteers were found to be suitably vetted and supervised in their roles. The provider has a contract with a staffing agency which on occasion provides staff and the contract included the requirement that the agency confirm they have sourced all of the relevant documentation for safe recruitment. The staff were trained in a range of suitable and varied disciplines including social care, social studies and or nursing and special needs and caring for people with disabilities. Staff on overnight duty in the centre must have a professional qualification.

There was evidence of annual appraisals and performance reviews undertaken which focused on training and development and an induction system was in place. However, the system for relief staff induction to the specific houses was not clear and in one instance not satisfactory. Team meetings take place with the clinical nurse managers to monitor care.

Mandatory training requirements including safe moving and handling the protection of vulnerable adults were up to date. The outcome on fire training has been detailed under Outcome 7. A range of internal training which is pertinent to the resident population is available for staff. This includes training in autism, introduction to dementia, challenging behaviours and CPI. Training in safe swallowing and palliative care had been provided to some staff. This training schedule was ongoing with 2014 already planned and included medication management and the management of epilepsy.

There was a knowledge and understanding of the standards and regulations evident. Staff spoken with demonstrated an in-depth understanding of the needs and wishes of the residents, and competency in their work. Communication observed was found to be open, supportive respectful and warm.

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:

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Ltd
Centre ID:	OSV-0003556
Date of Inspection:	11 June 2014
Date of response:	4 July 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:
The personal plans available did not consistently reflect or incorporate the assessed needs of the residents.

Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
The Person in Charge will ensure that:-
- Admission policy is being reviewed

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

- Admission policy to include requirement to complete a comprehensive assessment process and personal plan within 28 days of admission.

Proposed Timescale: 01/09/2014

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not direct systems for the identification of risk including that of missing residents, self harm and accident and injury as required by the regulations.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The Provider will ensure that:-
A Health Safety and Risk Management Policy Sub Group has been established to review and update our current policy. This policy will include a Risk Assessment Form and will also contain procedures for:
a. Unexplained absence of residents.
b. Accidental Injury to residents, visitors and staff.
c. Aggression and violence.
d. Self Harm.

Proposed Timescale: 01/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Hazards and risks in the physical environment had not been adequately assessed and remedied. This included risks observed in the garage area of one section of the centre.

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:
The Provider will ensure that:-
A Health Safety and Risk Management Policy Sub Group has been established to review

and update our current policy. This policy will include a Risk Assessment Form and will also contain procedures for:
a. Unexplained absence of residents.
b. Accidental Injury to residents, visitors and staff.
c. Aggression and violence.
d. Self Harm.

Proposed Timescale: 01/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the management and prevention of infection was not centre-specific and did not provide sufficient guidance for staff.

Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
The provider undertakes to develop centre specific systems to support the prevention and control of infection.

Proposed Timescale: 30/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Equipment provided for the extinguishing of fires was not consistently maintained in working order.

Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
Fire extinguisher was serviced on 13th June 2014

Proposed Timescale: 13/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No suitable fire detection alarm system was available in one section of the centre.

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:
Integrated fire detection alarm system was installed and commissioned.

Proposed Timescale: 27/06/2014

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:
All healthcare interventions recommended by a medical practitioner were not consistently implemented with specific regard to the management of epilepsy and interventions such as referral to dieticians.

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 Person in Charge will ensure that:-
• The immediate services deficit was addressed on 18th June 2014.
• Programme has been developed for 6 monthly and annual reviews by local managers of documentation
• The Epilepsy Guidelines is in development underpinned by the National Clinical Programme in Epilepsy.
• Training commenced in May 2014 on Epilepsy – Community staff will commence training by 1st September 2014

Proposed Timescale: 01/09/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Policy on the care and support of residents with regard to end of life care had not been developed.

Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
The Person in Charge will ensure that:-
• An End of life policy is being developed in partnership with HSE Dublin-Mid-Leinster.
• A Guideline for Individual support plans at times of illness is being developed

Proposed Timescale: 31/12/2014

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:
Policy on the management of medication was not sufficient to guide safe practice.

Action Required:
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
Currently there is a medication policy committee who are in the process of a complete update of this centre's medication policy. An early draft of the main procedural issues will be issued in July 2014 with a signature sheet to be signed by nurses to verify they have read and understood the policy. The policy for disposal will be in this early draft.

Review all locations of medicine storage and replace as appropriate. Completion by 1st August

Proposed Timescale: 01/08/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff rostering arrangements and arrangements for relief cover do not currently ensure that all interventions and care needs of residents are implemented.

Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
A roster review has commenced to identify gaps which could be filled by regular staffing
A dedicated site specific relief panel will be identified by 30th September 2014

Proposed Timescale: 30/09/2014