Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Centre 1 - Cheeverstown House Residential Services (Younger Persons)
Centre ID:	OSV-0004924
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Limited
Provider Nominee:	Paula O'Reilly
Lead inspector:	Karina O'Sullivan
Support inspector(s):	Michael Keating
Type of inspection	Unannounced
Number of residents on the date of inspection:	13
Number of vacancies on the date of inspection:	7

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
05 October 2016 08:30	05 October 2016 19:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
An initial inspection in 2014, was completed as a result of the provider submitting an application to register this designated centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, at the time the designated centre was not found to be in sufficient compliance with the regulations in order for the chief inspector to grant registration. Following this, meetings were held between the provider and HIQA and subsequent action plans were agreed. An unannounced inspection took place in November 2015, and improvements were identified however, a number of issues remained outstanding. Poor managerial oversight and governance arrangements continued to be impacting upon the quality of lives for residents. The complex governance and management arrangements did not identify lines of authority and accountability. Subsequently in early 2016 HIQA issued the provider a timeline to implement appropriate arrangements in relation to assigning appropriate persons in charge.

The provider put persons in charge in each designated centre. The person in charge of this designated centre was subsequently interviewed in June 2016. This inspection was primarily to ensure the revised governance arrangements were having a positive outcome for residents and to ensure agreed actions were being implemented. During this inspection inspectors found improvements, however, some actions submitted to HIQA remained outstanding. These are identified within the main body of this report.

How we gathered our evidence:
As part of the inspection inspectors visited three houses within the designated centre, two were based within a campus setting and one based within the community. A fourth house was currently being used on a temporarily bases for other residents, as renovations were ongoing within other locations. Inspectors met with ten residents and eight staff members. Inspectors viewed documentation such as, care plans, person-centred support plans, recording logs, policies and procedures.

Description of the Service:
This designated centre consisted of three houses, one house was based in Dublin 24 and the other two houses where located in Dublin 6W operated by Cheeverstown House Residential Services. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The designated centre aimed to provide community residential support to male and female adults with intellectual disabilities.

Overall Judgment of findings:
Twelve outcomes were inspected against. Two outcomes were found to be in full compliance. Two outcomes were found to be substantially compliant, seven outcomes were found to be moderately non-compliant and one outcome was found to be in major non-compliance, this related to medication. Other areas of improvement included health and safety and information contained within both healthcare and personal plans.

Four staff members facilitated the inspection as the person in charge was not on available on the day of inspection.

All proposals outlined and plans agreed will be verified at the next inspection.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors reviewed this outcome in respect of the actions identified in the previous inspection. Inspectors found two of the three actions were achieved. In addition, inspectors identified improvements were required in relation to the complaints policy and the management of residents finances.

Inspectors found the system in place within the designated centre was not effective in relation to the management of complaints. Inspectors viewed the recording log, this identified complaint's were addressed and were signed off by staff members and the person in charge. Despite this inspectors found some of these complaints remained unresolved on the day of inspection. For example, one such entry was dated 03 July 2016 this was signed off on the 28 of August 2016. However, on the day of inspection this remained outstanding.

Inspectors also viewed evidence of residents purchasing prescribed products from their own personal funds. Inspectors brought this matter to the attention of the clinical nurse manage one on the day of inspection.

Inspectors found there was a complaints policy and procedure in place, however, the complaints procedure did not specify a nominated person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure all complaints were appropriately responded to and a record of all complaints maintained.

Residents had access to and were made aware of both the national and internal

advocacy services.

Inspectors found accessible versions of the complaints procedure available and on display within the designated centre.

Judgment:
Non Compliant - Moderate

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

Findings:
Inspectors reviewed this outcome in respect of the action identified in the previous inspection. Inspectors found the action was achieved.

Residents now had written agreements in place.

Judgment:
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):
No actions were required from the previous inspection.

Findings:
An updated action plan was submitted by the provider at the request of HIQA. This outlined progress in relation actions required. However, of the three actions detailed, two of these remained outstanding in relation to ensuring residents had up-to-date personal plans in place and goals identified were reviewed.

The organization had deployed a service improvement team to provide guidance on personal plans. This new system of social care planning was implemented throughout the designated centre. Inspectors acknowledged improvements within many of the care plans reviewed. However, some residents did not have their personal plans updated to reflect their current assessed needs.

Within other plans inspectors found goals set were not reviewed nor was there evidence of progression in relation to areas identified such as, swimming.

Inspectors found some resident's social care needs were identified and residents had the opportunity to participate in meaningful activities appropriate to their interests and preferences. These included areas such as, attending music events, meeting friends and shopping.

Residents' family members were consulted in relation to the personal plans in line with residents and family members' preferences. There was evidence of this maintained within the resident's files.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
Inspectors reviewed this outcome in respect of the actions identified in the previous inspection. Inspectors found the action was achieved.

Inspectors found significant improvements had occurred to the layout of the houses to meet the assessed needs of residents in a person-centred homely environment.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
Inspectors found the designated centre was suitable and safe for the number and needs of residents. Actions identified in the previous inspection had been addressed. Improvements were required in the areas of risk assessments and the management of sharps.

Sharps were used within the designated centre and inspectors requested to see documentation in relation to the management and disposable of sharps. This was not available. There was no label or tagging system used for the sharps bin.

There were individual risk assessments for residents in place these included displays of behaviours, unexplained absence and trips and falls. Inspectors found this system required improvement as information contained in some individual risk assessments did not reflect practice.

There was certification and documentation to show the fire alarms, emergency lighting and fire equipment were serviced by an external company as required by regulations.

Fire drills had taken place and documents recorded the time taken to evacuate, inspectors viewed four of these. Any issues were identified along with the identification of residents, who had participated in the drill within the designated centre.

The designated centre had an organizational risk management policy in place this included, the specific risks identified in regulation 26. The designated centre had a risk register and this recorded a number of risks within the houses and the controls in place to address these.

The designated centre had a health and safety statement dated 15 October 2016. This outlined the responsibilities of the various staff members within the organization. The statement referenced a wide range of policies and procedures that supported the statement and guided staff in their work practices. The designated centre had an emergency evacuation plan in place for a number of various events such as, fire, adverse weather conditions, flooding and power failure. The plan identified specific alternative accommodation to be provided in the event residents could not return to the

designated centre. The HSE (Health service executive) guidelines for lone working dated September 2014 was present within one house however, this was not implemented. There were no specific guidelines to guide staff in the area of lone working within the designated centre.

There was a system in place for recording accidents and incidents occurring in the designated centre. Staff outlined the process for dealing with these and ensuring learning from any adverse incidents or accidents occurred.

Judgment:
Substantially Compliant

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

Theme:
Safe Services

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

Findings:
An updated action plan was submitted by the provider at the request of HIQA, this outlined progress in relation actions required. However, of the four actions detailed, one of these remained outstanding in relation to ensuring behaviour support plans were guiding practice.

Improvements were required in relation to behavioural support plans. The following areas were identified:

- one behaviour support plan contained specific interventions. These were not implemented within practice for example, two staff members were required. From discussions with staff members and from observations one staff member implemented the interventions

- "things that cause me distress" was outlined for one resident, this specified new people they were not familiar with. On the day of inspection seven additional staff members not contained within the rota were present within the house. Inspectors found the reliant on relief staff (new people) was not person-centred for the assessed needs of this resident

- another plan viewed identified "extremely distressed" however, there was no identification of what indicator's the resident exhibited when in this state of distress. Inspectors found this did not guide staff particularly when the designated centre was reliant on relief staff members

- recording of incidences were not accurately reflected in behavioural recording charts.

There were plans in place for providing intimate care to residents whom required support in this area. However, some of the information contained within these plans were not implemented in practice. For example, one plan specified the resident preferred a bath. On the morning of the inspection inspectors, overheard this resident vocalising loudly. Staff members confirmed the resident was refusing to have a shower. Inspectors found this aspect of care provision was not person-centred. Inspectors also viewed another example, where different interventions were in place for the same resident on the day of inspection in relation to assisting a resident with their elimination needs. Inspectors found this practice lead to inconsistent care provision.

There was a policy in place on the prevention, detection and response to abuse this was dated August 2014.
Staff members had received training in the area of prevention, detection and response to abuse.

Inspectors found significant improvement had occurred in the designated centre in relation to removing environmental restrictions.

Inspectors found residents were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Inspectors found some residents were supported to achieve the best possible health. Improvements were required within the details in the interventions specified for some

healthcare needs. The review of the effectiveness of the interventions also required improvement.

The healthcare needs of residents were completed via a plan incorporating nine areas of assessments. These included areas such as, communication, breathing and circulation, nutrition and hydration, continence and elimination, personal care, meaningful activities and sleep and rest. This was a new system implemented since the previous inspection.

- inspectors viewed these healthcare plans and found some of these required improvement in the area of review and implementation of the interventions identified. For example, monthly weights were identified due to a score of 0 with in a MUST (malnutrition universal screening tool), however, the last weight was obtained in March. Another resident's plan identified weekly weights were to be obtained from viewing the documentation present this was only completed monthly

- there was no guidance for staff in relation to the use of pressure relieving mattresses. One such devise was on locked mode and staff were unfamiliar in relation to the settings this should be set at

- some pressure sore assessments and pain assessments were blank despite some resident receiving pain relief. Inspectors found this was not in accordance with the designated centre's guidelines as some staff identified a pain assessment was to be completed for the residents inspectors asked about

-another plans viewed contained goals and interventions identified on the 08 March 2016 these were to be reviewed in three months as stated within the document. No review took place, nor was there any evidence of what progression had taken place in relation to these goals and interventions

- some interventions were not guiding practice effectively for example, maintain normal BMI (body mass index) no identification was present in relation to what this was for the resident

- inspectors viewed an epilepsy plan in place, this did not contain a date or when this document was due to be reviewed. Inspectors were unable to identify how current this document was

- inspectors found the availability of mobility equipment was not provided in a timely manner. For example, one resident required both a shower chair and a regular chair. Inspectors acknowledged the complex medical condition of the resident and the progress made in relation to meeting significant healthcare needs of this resident. An assessment had been arranged to provided appropriate mobility equipment at the time of inspection

- inspectors found the number of goals and interventions set were excessive in relation to the resources within the designated centre. For example, 17 goals and 103 interventions were specified within one care plan.

Residents had access to allied healthcare professionals, inspector viewed evidence of

this including physiotherapy, occupational therapist and psychiatrist.

Residents requiring modification to the texture of their food was clearly outlined in the residents file. Staff members were knowledgeable in relation to the implementation of resident's food requirements. Inspectors viewed feeding, eating, drinking and swallowing (F.E.D.S) assessments in place for some residents.

Regarding food and nutrition inspectors found residents participating in mealtimes within the designated centre in accordance with residents' preferences in relation to food choices. Residents participated in meal preparation in accordance with their own preferences.

Inspectors viewed user-friendly menu selection of refreshments and snacks were available for residents outside mealtimes within the designated centre.

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

Findings:
Inspectors found the actions from the previous inspection had been achieved. Significant improvements were required in relation to oversight of the medication management system and the administration practices within the designated centre required improvement.

Non-compliance identified with regulations included:

- the opening dates or name of the resident was not recorded for some medications for example, creams

- some rescue medication plans were not reflective of the administration documents for example, the second administration of the specified medication

- prescribed rescue medication was not in stock on the day of inspection, inspectors asked how long this was the case, however, this information was unavailable. From viewing records present no stock of this medication was ordered in August or September 2016. Inspectors asked staff to talk them through the process should this medication be

required. Staff members present identified they would use other residents supply of the medication once it was of the same strength. Inspectors asked to view this supply and found all rescue medication out of date. Inspectors identified this practice was unsafe and not in accordance with nmbi (Nursing and Midwifery Bord of Ireland). Within this designated centre nursing staff were responsible for administrating medication

- no guidance was available for some p.r.n (a medicine only taken as the need arises) medication in relation to residents prescribed two medications for the same symptoms. No guidance was available to staff when one medication could be administer instead of the other or if both medications should be administered. Staff members were unable to identify to inspectors when these medications would be administered and why. However, one member of staff identified pain assessment were completed. On review of the incidences when these medications were administrated no assessments had taken place

- other medication did not contain an expiry day within the label

- some administration recording sheets did not match the administration record for example, pain relief medications

-the designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. Medication was supplied to the designated centre by pharmacist based within the organization, medication was recorded when received. Inspectors found improvements were required within this recording system as some elements of this document were left blank

- inspectors viewed the system in place for recording, reporting errors and reviewing medication. Inspectors found this system to be ineffective. A medication error was viewed dated 27 July 2016 this related to an over dosage of medication. This was completed by frontline staff and sent to the manager's office. Inspectors found no action had been taken nor was any details completed within the form. The manager's actions and follow up section was blank. The clinical nurse manager three identified this was not yet completed. Inspectors found the timeline to complete this excessive and unsafe.

Inspectors observed all medication was stored in a secure, locked cabinet in a locked area. The keys to access the medication cabinet were held securely by staff.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found the statement of purpose did not fully meet the requirement of the regulations as outlined in schedule 1. One of the two actions remained outstanding in relation to the staffing levels being accurately described.

Appendix 1 of the document required updating.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found the three actions from the previous inspections were achieved. Inspectors did identify some improvements in the governance and management of the designated centre. This included the appointment of a person in charge and an on call system available to staff members. However, improvements were required in the area of accountability and the follow up of audits completed.

Inspectors observed auditing of areas within the designated centre. Inspectors viewed some audits for example, medication and found areas outstanding since 13 March 2016. Inspectors also identified medication audits were not completed twice a year as specified within documentation. Inspectors viewed one completed on the 20 September 2015 no other audit was completed in 2015 with one completed in 2016. Inspectors also identified lack of follow up in relation to audits of residents plans. However, inspectors did identify incremental improvements in relation to audits as these were now taking place since the previous inspection.

Inspectors found there was a clearly defined management structure with lines of authority in place. However, the lines of accountability were unclear among the layers of management within the designated centre. Inspectors found several incidences of this during the inspection. For example, the actual person allocated to management could alter the care provision. In some incidences the clinical nurse managers administered medication within houses when there was no nurse available. However, on other occasions the nurse from another house had to be relieved to go to another house to administer medication. On the day of inspection the designated centre was short staffed and there was one clinical nurse manager three and one clinical nurse manager one on duty allocated to administrative duties.

Inspectors found an annual review of the quality and care completed in this designated centre for 2015.

Staff performance reviews had commenced within the designated centre.

The provider had carried out an unannounced visit on a six monthly basis. This reviewed the safety and quality of care and support provided in the designated centre. Inspectors viewed the previous one completed in each of the houses individually.

Judgment:
Non Compliant - Moderate

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

Theme:
Responsive Workforce

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

Findings:
Inspectors found the designated centre did not have sufficient staff numbers with the right skill mix, qualifications and experience to meet the assessed needs of the residents. Inspectors found improvements were required in relation to the provision of consistent staff members and the maintenance of an accurate rota.

Inspectors viewed the proposed and actual staff rota and found these were not accurately maintained. This was also identified in the previous inspection On the day of

inspection support was received from day service staff however, this was not reflective on the rota. Inspectors also found this impacted on the provision of care to residents for example, inspectors observed one resident receiving support in relation to elimination. This was provided on three occasions within a short period of time by three different members of staff using two different methods. Inspectors found this was not person-centred. Nor were these staff members collaboratively working together to provide effective and consistent care provision to residents.

Inspectors found staff received appropriate training within the sample of training records viewed.

Staff files were not reviewed as part of this inspection as these are held within an office off site these were reviewed as part of the previous inspection.

These were no volunteers within the designated centre.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Inspectors reviewed this outcome in respect of the action identified from the previous inspection. Inspectors found one action remained outstanding in relation to information contained in residents' files.

The retrieval of some schedule 3 documents was difficult. Some documents were present in duplicate versions for example, individual risk assessments. Other aspects of residents' assessments were left blank and undated. Inspectors found these documents did not guide staff effectively in the areas of care delivery.

Inspectors also found schedule 5 polices were not maintained within the designated centre for example:

- recruitment, selection and Garda vetting was dated 2004

- staff training and development was dated 2009

- monitoring and documentation of nutritional was not yet available within the designated centre

- provision of behavioural was in draft format

- the use of restrictive procedures and physical, chemical and environmental restraint was in draft format.

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:

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Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004924
Date of Inspection:	05 October 2016
Date of response:	16 November 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident purchased items prescribed for them from their own funds.

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

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

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

Please state the actions you have taken or are planning to take:
The cost of Prescribed Item was reimbursed through Financial Department in Cheeverstown on the 31st of May 2016 to the family and this is now documented with in the ledger under personnel item. The financial procedure will be outlined with staff at team meetings during November.

Proposed Timescale: 30/11/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure all complaints are appropriately responded to and a record of all complaints are maintained.

2. Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
Safe guarding administration staff will audit all complaints to ensure that they are appropriately responded to in a timely manner, all records are maintained and the complainant is satisfied with the process.

Proposed Timescale: 31/12/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Information contained within the complaints log within the designated centre was inaccurate.

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

Please state the actions you have taken or are planning to take:
New audit system for complaint procedure to be implemented by nominated person as newly outlined under regulation 34(3).

Proposed Timescale: commence January 2017

Proposed Timescale: 31/01/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents did not have their personal plans updated to reflect their current assessed needs.

4. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
The PIC will devise a schedule of review for each individual Plans across DC1 The personal plan will be completed annually but will be updated more frequently according to individuals changing needs.

Proposed Timescale: Commence January 2017

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Goals set were not reviewed nor was there evidence of progression in relations to areas identified.

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:
During the process of the keyworker reviewing the individual's plans all goals will be incorporated into the process to ensure the effectiveness of the plans.
The PIC and their delegate will support and audit this process.

Proposed Timescale: Commence January 2017

Proposed Timescale: 31/01/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no label or tagging system used for the sharps bin.

Some individual risk assessments were not implemented.

6. 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:
Labelling of sharps box completed.
Draft guidelines gone out for consultation across all designated centres
Risk register will include risk assessment for sharps bin.

Proposed Timescale: 16/12/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have up-to-date knowledge, to respond to displays of behaviour as behaviour plans were not reflective of current practice.

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

Please state the actions you have taken or are planning to take:
Positive Support Plan reviews for DC1 has commenced with psychologist and team including keyworkers.
The PIC will ensure key staff are supported and mentored to familiarise themselves with each person's plan around their assessed needs as they are completed.

Proposed Timescale: 28/02/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Measures to alleviate some displays of behaviours were not evident.

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

Please state the actions you have taken or are planning to take:
Positive Support Plan reviews for DC1 has commenced with psychologist and team including keyworkers.
The plan will ensure that all measures to alleviate displays of behaviour and distress are documented.

Proposed Timescale: 28/02/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Intimate care was not provided in line with resident's personal plan.

9. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
Personal and Intimate care plans to be reviewed in DC1
Induction sheets have been updated for relief /agency staff in keeping with personal plans

Proposed Timescale: Commenced November 2017 ongoing

Proposed Timescale: 30/11/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Healthcare plans required improvements in the area of review and implementation of the interventions identified to establish levels of effectiveness.

Some interventions were present for residents without any guidance for staff members and other interventions were not detailed enough to guide practice.

Epilepsy plans were undated.

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

Please state the actions you have taken or are planning to take:
PIC and their delegate will audit the personnel plan including health care documentation and guide staff practice. The effectiveness of the individual plan will be included in the review for evaluation.

Proposed Timescale: 28/02/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident was not supported in a timely manner in relation to the provision of care to meet their physical needs.

11. 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:
Documentation regarding assessments and end of life plans including recommendations and decisions will be reviewed and improved for evidence and communication.

Proposed Timescale: 28/02/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Rescue medication was out of date and remained in the designated centre new stock was not available for administration.

12. Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
In date rescue remedy was put in place on the 5/10/17.
In conjunction with the Pharmacist the medication ordering form for PRN has been re designed to ensure better practice.

Proposed Timescale: 30/11/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The opening dates or name of the resident was not recorded for some medications for example, creams.

Some rescue medication plans were not reflective of the administration documents for example, the second administration of the specified medication.

No guidance was available for some p.r.n. medication.

Some medication did not contain an expiry day within the label.

Some administration recording sheets did not match the administration record for example, pain relief medications.

The system in place for recording, reporting errors and reviewing medication was ineffective.

13. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
Meeting held with PIC and pharmacist on 14th of November 2016. Policy and procedure review has commenced to include GP prescribing practice. Implementation plan for staff familiarisation will be included.
Medication error reporting process including risk management system will be reviewed to ensure its effectiveness.

Proposed Timescale: 30/04/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the information set out in Schedule 1 was not accurately reflected in the statement of purpose.

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

Please state the actions you have taken or are planning to take:
A review of the document has commenced to ensure the statement of purpose contains all information as laid out in Schedule 1.

Proposed Timescale: 05/12/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The lines of accountability within the designated centre were not clearly identified in relation to responsibilities for all areas of service provision as practice depended on the actual person on management duties.

15. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
A review of the role and function of the PIC and other management grades will provide clarity regarding the overall function responsibility and accountability

Proposed Timescale: 31/12/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Follow up on some audits completed was not evident.

16. 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:
Adherence to system of documentation required will be completed to provide evidence of actions completed. All audits completed included medication management will be accountable to the line management structure (CNM3) for monitoring and auditing.

Proposed Timescale: 02/12/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The actual staff rota did not reflect the staff present within the designated centre.

17. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
The system and documentation for the actual rota will be updated to ensure it includes all staff present at all times.

Proposed Timescale: 02/12/2016

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Continuity of care and support was not facilitated at all times within the designated centre due to the volume of staff members providing support to residents.

18. 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:
The PIC with the nominated provider and HR manager will continue with recruitment to ensure consistency of staffing for continuity of care and support.
Recruitment for new Support Team Coordinator/Relief manager is underway and when in place will help coordinate the use of float staff to ensure they are assigned to where their skills match individual assessed needs.
A documented Contingency Plan for when staffing levels are low is in draft and will also address issues related to continuity of support.

Proposed Timescale: 09/01/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the policies and procedures set out in Schedule 5 were not available for example:

- monitoring and documentation of nutritional was not yet available within the designated centre

- provision of behavioural was in draft format

- the use of restrictive procedures and physical, chemical and environmental restraint was in draft format.

19. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
All policies and procedures as set out in Schedule 5 of the Health Act 2007 have been compiled in a folder and formatted for this designated centre.

All policies as set out in Schedule 5 have been made available electronically on an organisation wide shared folder and all staff will be made aware of how to access this folder during a policy information day scheduled to take place in November 2016

Proposed Timescale: 30/11/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some policies were not reviewed at intervals not exceeding 3 years foe example:

- recruitment, selection and Garda vetting was dated 2004

- staff training and development was dated 2009.

20. Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
A schedule of reviews for all policies has been set out and implementation plans have been updated and included in the Schedule 5 policy folder where applicable. All policies will be reviewed at intervals not exceeding 3 years.

The HR policies will be reviewed before the end of January 2017.

Proposed Timescale: 30/01/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The retrieval of some schedule 3 documents was difficult. Some documents were present in duplicate versions other parts of documents were blank and undated.

21. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
An audit will be completed by staff for each of the individual personal files under the supervision of the PIC. This audit will be in keeping with the records identified in the schedule 3.

Proposed Timescale: 01/02/2017