Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Centre 8 - Cheeverstown House Community Services (Kingswood/Tallaght)
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Announced
Date of inspection:	26 and 27 September 2018
Centre ID:	OSV-0004131
Fieldwork ID:	MON-0021874

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The service provided was described in the providers statement of purpose, dated August 2018. The centre provided residential care and support to 11 adults and respite care to 4 adults at any one time. The centre consisted of five separate units in the community and within the geographical area of Tallaght, Dublin 24. There were three two storey residential homes in the community, one two bedroom apartment in an apartment complex and one level access house. There were nice sized gardens to the rear of each of the houses and small but secure patio area at the back of the ground floor apartment. Each of the residents living in the centre or availing of respite had their own bedroom which had been personalised to their own taste. The last inspection in the centre had been completed in September 2016. The purpose of this inspection was to inform a registration renewal decision for the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
26 September 2018	08:30hrs to 18:30hrs	Maureen Burns Rees	Lead
27 September 2018	08:30hrs to 13:30hrs	Maureen Burns Rees	Lead

Views of people who use the service

As part of the inspection, the inspector met with ten of the fifteen residents living in the centre and observed elements of their daily lives at different times over the course of the inspection. Although, a number of these residents were unable to tell the inspector about their views of the service, the inspector observed warm interactions between the residents and staff caring for them and that the residents were in good spirits. Other residents told the inspector that they enjoyed living in their respective houses and that staff were very good to them. A number of the residents had completed a HIQA questionnaire regarding the quality of the service with the assistance of a staff member. Overall, these suggested that the residents were satisfied with the service and the care being provided. Two of the residents had moved out from the providers campus based setting within the last two years and it was evident that the move had significantly improved their quality of life.

The inspector found that residents were enabled and assisted to communicate their needs, wishes and choices which supported and promoted residents to make decisions about their care. One of the residents was a member of a leaders group and an advocacy group within the wider service and shared with her peers information from these groups. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits. The inspector did not have an opportunity to meet with the relatives of any of the residents but it was reported that they were happy with the care and support their loved ones were receiving.

Capacity and capability

There were management systems in place to ensure that the service provided was safe, consistent and appropriate to the resident's needs. However, some improvements were required to ensure that staffing levels were sufficient to meet the needs of residents living in the centre.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge had been in the position for more than two and a half years but had been working within the service for seven years in management positions. She was a registered nurse in intellectual disabilities and held a management qualification. She was found to have a sound knowledge of the care and support requirements for each of the residents. She was in a full time post and was not responsible for any other centre. Staff members spoken with, told the inspector that the person in charge supported them in their role. The person in charge reported that she felt supported in her role and that she had regular contact with her manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their

responsibilities and who they were accountable to. There was a respite coordinator in place for the respite service. She reported to the person in charge. The person in charge reported to the interim community manager who in turn reported to the chief executive officer. The interim community manager had been in position for the past two months but the position had been unfilled for a short period before that.

The provider had completed an annual review of the quality and safety of care in the centre and six monthly unannounced visits to assess the quality and safety of the service as required by the regulations. A number of other audits had been undertaken and there was evidence that actions had been taken to address issues identified. Examples of audits completed included, medication, finance, 'my life plan' and complaints.

There were appropriate arrangements in place for the admission and discharge of residents to and from the centre. At the time of the last inspection, the admission policy did not reflect admission practices nor was the document available within the designated centre. Since that inspection, the admission policy had been revised and was available in the centre. Contract of care agreements had been drafted for each of the residents. However, it was noted that contracts on some residents files had not yet been signed by the identified resident and or their representative.

There were effective staff recruitment and selection arrangements in place. The identified complement of staff for the centre were in place. This ensured consistency of care for the residents. A formal staff support needs assessment to determine required staffing levels based on dependency requirements had been completed. However, on this of inspection, the inspector found that the support arrangements and staffing levels in one of the units, specifically at night were not sufficient to meet the needs of two of the residents. Following a request for assurances, the provider put additional staffing resources in place to support residents pending a review of support arrangements. Otherwise, the staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. On-call arrangements were in place for staff.

An actual and planned staff roster was in place and maintained. A new computerised 'live roster' had been introduced on the week preceding this inspection. This roster reflected the staffing levels on duty on the day of inspection and identified the lead members of staff.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy. A training programme was in place which was coordinated by the providers training department. Training records showed that staff were up-to-date with mandatory training requirements. Other training to meet specific needs of residents had been sourced.

Formal staff supervision arrangements were in the early stages of being developed in the centre. This meant that staff might not be appropriately supported so as to ensure that they performed their duties to the best of their abilities. A draft supervision policy had been developed. Formal supervision was in the process of

being rolled out for all staff. It was proposed that the person in charge would complete formal training on completing supervision with staff.

There was an effective complaints procedure in place which met the requirements of the regulations. Overall, there were a low number of complaints in the centre but these had been appropriately managed.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

Support arrangements and staffing levels in one of the units, specifically at night were not sufficient to meet the needs of two of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. Formal staff supervision arrangements were in the early stages of being developed in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

There were appropriate arrangements in place for the admission and discharge of residents to and from the centre. Contracts of care which clearly listed the services provided and fees payable were in place. However, it was noted that contracts on some residents files had not yet been signed by the identified resident and or their representative.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a written statement of purpose, dated August 2018, that accurately described the service that was provided in the centre and contained the information set out in schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre were maintained and where required, notified to the Chief Inspector and within the timelines required in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in place which met the requirements of the regulations.

Judgment: Compliant

Quality and safety

Overall, the residents living in the centre received care and support which was of a

good quality, safe, person centred and which promoted their rights.

The residents' well-being and welfare was maintained by a good standard of evidence-based care and support. Care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal and social needs and choices. Personal plans in place had been reviewed. However, reviews undertaken did not always involve members of the multidisciplinary team or the residents family. Overall, reviews did not assess the effectiveness of the plans in place.

Residents were supported to engage in meaningful activities in the centre and within the community. The majority of the residents attended a day service. Staff facilitated and supported the residents to travel to and from their day service and to participate in activities that promoted community inclusion such as, a social club, bowling, gym, meals out and shopping trips, beautician visits, the cinema, nature walks and garden festivals. Personalised weekly activities schedules were in place for residents.

The centre comprised of five separate units. There were three two storey residential homes in the community, one two bedroom apartment in an apartment complex and one level access house. There were nice sized gardens to the rear of each of the houses and a small but secure patio area at the back of the ground floor apartment. Each of the residents had their own bedroom which had been personalised to their own taste. The units were located a short distance by car from each other. Each of the houses were found to be suitable to meet the resident's individual and collective needs in a comfortable and homely way at the time of inspection. The bathrooms in two of the houses were identified to require updating and the bathroom floor in one of the bathrooms was observed to be worn and to require replacement. There were steps at the back of one of the houses which were difficult for the resident to use when accessing their back garden. There was evidence that an application had been made to have the steps removed and replaced with a ramp.

Residents' communication needs were met. Individual communication requirements were highlighted in residents' personal plans and reflected in practice. There was a communication policy dated July 2015. Communication passports were on file for residents who required same. A small number of residents were non-verbal. Staff were observed to communicate well with these residents using visual cues such as, picture exchange and object of interests. These were noted to assist the residents to choose food choices, activities, daily routines and journey destinations.

The residents were provided with a nutritious, appetizing and a varied diet. There was a food, nutrition and hydration policy, dated October 2016. The timing of meals and snacks throughout the day were planned to fit around the needs of the residents. A weekly menu was agreed with residents at a weekly meeting in each of the houses. A healthy eating programme was promoted in each of the houses.

The health and safety of residents, visitors and staff were promoted and protected. There were risk management arrangements in place which included a detailed risk

management policy. Environmental and individual risk assessments and safety plans had been completed and were reviewed at regular intervals. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified.

There were arrangements in place for investigating and learning from incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences. The providers risk management department provided an analysis report of incidents on a periodic basis, which facilitated trends to be identified.

Precautions were in place against the risk of fire. However, in the respite house it was observed that the break glass unit to hold the key for one of the back doors was broken and that a key for a side gate was not readily available to access the assembly point. Records of fire drills undertaken did not always include the names of respite service users who participated in the drill and there was no process in place to ensure that all respite service users were involved in a fire drill. In addition, the keys for a side gate in one of the other houses were not readily available. Otherwise, adequate means of escape from each of the houses were observed and a fire assembly point was identified. There was documentary evidence that fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company. A procedure for the safe evacuation of residents in the event of fire was prominently displayed in each of the houses. Resident's had a personal emergency evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Staff who spoke with the inspector were familiar with the fire evacuation procedures and had received appropriate training. Fire drills involving residents had been undertaken at regular intervals.

Residents were provided with appropriate emotional and behavioural support. There was a policy on promoting positive approaches, meeting needs and reducing distress. The inspector found that the assessed needs of residents were being appropriately responded to. In general residents presented with minimal behaviours that challenge. Compatibility issues were identified in one of the houses but these were being managed at the time of inspection. Suitable information was provided within residents personal support plans to guide staff in meeting the needs of individual residents.

There were measures in place to keep residents safe and to protect them from abuse. The provider had a safeguarding policy and procedure, dated April 2018. Staff members spoken with, were knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. All staff had attended appropriate safeguarding training. There had been a small number of safeguarding concerns which were appropriately managed. There were safeguarding plans in place for a small number of residents identified to require same. Intimate care plans were in place for individual residents and found to contain a good level of detail to guide staff in meeting the intimate care needs of individual residents.

Regulation 10: Communication

The communication needs of residents had been appropriately assessed with appropriate supports put in place where required.

Judgment: Compliant

Regulation 17: Premises

The centre comprised of five separate units, which were found to be homely, accessible and promoted the privacy, dignity and safety of each resident. However, the bathrooms in two of the houses were identified to require updating and the bathroom floor in one of the bathrooms was observed to be worn and to require replacement.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with a nutritious, appetizing and varied diet.

Judgment: Compliant

Regulation 26: Risk management procedures

The health and safety of residents, visitors and staff were promoted and protected.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable precautions were in place against the risk of fire. However, in the respite house it was observed that the break glass unit to hold the key for one of the back doors was broken and that a key for a side gate was not readily available to access the assembly point. Records of fire drills undertaken did not always include the names of respite service users who participated in the drill and there was no process

in place to ensure that all respite service users were involved in a fire drill. In addition, the keys for a side gate in one of the other houses were not readily available.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident's well-being and welfare was maintained by a good standard of evidence-based care and support. However, reviews undertaken did not always involve members of the multidisciplinary team or the residents family. Overall, reviews did not assess the effectiveness of the plans in place.

Judgment: Substantially compliant

Regulation 6: Health care

The healthcare needs of residents were being met.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional and behavioural support.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to keep residents safe and to protect them from abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Centre 8 - Cheeverstown House Community Services (Kingswood/Tallaght) OSV-0004131

Inspection ID: MON-0021874

Date of inspection: 26-27/09/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Review of support arrangements for one individual completed and updated plan of care reflects sleep over staffing arrangements as appropriate to meet individual needs Completed 28/09/2018 Following review by PIC ,MDT and Risk manager of reports from consultant neurologist, support staff and results of seizure monitoring device the persons plan of care has been updated to reflect that active night time supports are not indicated. Completed 23/11/2018	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Draft supervision policy will be approved and then rolled out across DC8 Supervision from CNM3 for PIC will take place quarterly, with a focus on support of the PIC in carrying out regulatory function and Cheeverstown policy and practice. Formal supervision will be rolled out across DC with the frequency to be every quarter with the focus during one of these sessions to be on performance management. Timeline Formal supervision was carried out between PIC and CNM3 on 13th September 2018 All staff in DC8 will be scheduled for formal supervision by Draft supervision policy will be approved and then rolled out across DC8 Supervision from CNM3 for PIC will take place quarterly, with a focus on support of the PIC in carrying out regulatory function and Cheeverstown policy and practice. Formal supervision will be rolled out across DC with the frequency to be every quarter with the focus during one of these sessions to be on performance management. Timeline	

Formal supervision was carried out between PIC and CNM3 on 13th September 2018
All staff in DC8 will be scheduled for formal supervision by 31/12/2018
Scheduled plan will be in place for 2019 which will identify one formal meeting every quarter. This schedule will compose of one performance development planning meeting and 3 formal supervision meetings.

Scheduled plan will be in place for 2019 which will identify one formal meeting every quarter. This schedule will compose of one performance development planning meeting and 3 formal supervision meetings.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Letters re Contracts of Care and fee sent to all representatives July 2018 advising of new fee to be charged from Sept 18.

Timeline
Letters have been reissued to families on 21/09/18 regarding unsigned documentation and advising families of revised long stay contribution giving representatives information of revised fees to be charged. PIC will follow up on the four outstanding documents by 31/01/2019

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Tenders have been issued as per Procurement Policy for upgrading of bathrooms in two locations. Awaiting one tender for completion of procuring process. Tendering process will be over seen by finance department for the application of funding to complete same.
Timeline
Bathroom floor covering replaced In September 2018
Decision on application for ramp at other location is due in Jan 2019, will progressed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Break glass unit in one location replaced. 28/09/2018
Key for side gate now in accessible location 28/09/2018
All individuals who are using respite services will participate in a further fire evacuation drill and documentation will reflect same. 31/01/2019

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Personal Plan Review form developed to be utilized by MDT for individual personal plan. The review which will be carried out annually or more frequently if there is a change of needs or circumstances.
These reviews will be multi-disciplinary and will assess the effectiveness of the plans in place. MDT reviews for DC8 completed on 16/11/2018

Timeframe
16/11/2018

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Yellow	23/11/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2018
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2019
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative	Substantially Compliant	Yellow	31/01/2019

	where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Yellow	31/01/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/01/2019
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	16/11/2018
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a	Substantially Compliant	Yellow	16/11/2018

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	16/11/2018