

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Centre 3 - Cheeverstown House Residential Services (Active Age/Senior Citizens)
Centre ID:	OSV-0004926
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):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
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, 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 unannounced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
21 September 2017 09:00	21 September 2017 20:20
22 September 2017 08:45	22 September 2017 19:50

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
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 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
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, this centre was not found to be in sufficient compliance with the regulations in order for the Chief Inspector to grant registration. Following this, meetings were held between the provider and the Health Information and Quality Authority (HIQA) and subsequent action plans were agreed. An unannounced inspection took place in November 2015 and improvements were identified, however, a number of issues remained

outstanding. Poor managerial oversight and governance arrangements continued to be impacting upon the quality of residents' lives. The complex governance and management arrangements did not identify clear 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 responded appropriately by appointing persons in charge to each designated centre. The purpose of this inspection was to inform a registration decision and to ensure the revised governance arrangements were having a positive outcome for residents. The inspector also followed up on the actions from the previous inspection to ensure agreed actions were being implemented. This inspection was completed over two days.

How we gathered our evidence:

As part of the inspection, the inspector visited four houses within the designated centre and spoke to 20 residents, met with three residents and seven staff members during the inspection. The inspector viewed documentation such as, care plans, person-centred support plans, recording logs, policies and procedures.

Description of the service:

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

Overall judgment of findings:

Some changes had occurred since the previous inspection, however, the inspector found that significant progress was not evident in order to bring about compliance with the regulations and improve residents' experience of living in the centre.

This inspection report identified 41 actions in need of address 13 of which were also identified on the previous inspection. This resulted in seven outcomes being evidenced as majorly non-compliant:

Outcome 1: Residents rights, Dignity and consultation

Outcome 5: Social Care Needs

Outcome 7: Health and safety and Risk management

Outcome 8: Safeguarding

Outcome 11: Healthcare

Outcome 14: Governance and Management

Outcome 17: Workforce

These areas required significant improvement to ensure that effective systems were implemented to ensure the quality and safety of the care provided in the centre was consistent and effective. Alterations to the workforce system were also required as the numbers of staff were not based on the assessed needs of residents.

Out of the remaining 11 outcomes inspected against, two were found to be in

moderate non-compliance, five were substantially compliant and four were compliant.

The person in charge facilitated the 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:

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

The inspector identified improvements in the area of respecting the privacy and dignity of each resident in relation to their living space. During both days, the inspector observed staff members from various locations on campus enter residents' homes without knocking or ringing the door bell. The inspector observed some of these people proceed through the home of residents without outlining the purpose of their visit.

On the second day of inspection, the inspector observed a resident enter another resident's bedroom and close the door. The resident remained in the room for a number of minutes before leaving the bedroom. Staff members were attending to other residents at the time this incident occurred. The inspector discussed this with staff members and was informed it was the resident's home and the resident liked to enter into other residents' rooms. The inspector identified this was not upholding the rights of all residents who lived within the house.

The inspector observed routines and practices which did not promote resident's independence or choice and in some instance staff members were not familiar with resident's individual preferences. The inspector observed residents walking around their home in their bare feet. This was not identified within residents' plans as a personal preference. On the second day of inspection, one resident sat at the kitchen table at 08:50hrs and remained there until 09:15hrs when a member of staff assisted the

resident to stand up and guided the resident towards the door way. This staff member did not identify to the resident where they were going. The person in charge identified to the staff member the resident had been sitting at the table for some time and had not received any breakfast. The staff member explained to the person in charge that the bath was full and ready for the resident to have a bath. The inspector found this practice did not facilitate a person-centred approach. The wishes of residents were not taken into account in some situations observed as outlined above.

On the second day of inspection, the inspector observed a staff member during breakfast place protective ware on one resident and fastened this around the resident's neck. This item was then laid out on the table in front of the resident with their cereal bowl and cup of tea placed on top of this. This inspector found this practice to be institutional, unsafe and restrictive in nature for the resident.

The practice of night checks were evident within the homes of residents, however, the rationale of some of these were unclear and not based on an assessment of resident's needs.

The inspector viewed the complaints log within the centre. Improvements were required in relation to the implementation of the complaints procedure and the follow up of some complaints. The inspector viewed from the records some complaints remained open since June 2016 in relation to the television reception. The inspector also viewed evidence of a complaint made by staff on behalf of a resident. This was contained on a handwritten piece of paper within the resident's file. This complaint did not go through the complaints procedure.

On viewing a sample of residents' finances, the inspector found some residents paid for items such as petrol, toll charges, food items, household products and medical procedures such as, electrocardiogram. The inspector requested to view evidence of the consultation which took place to result in this practice, however, this was not available.

One resident informed the inspector that they purchased their own vehicle. The inspector requested to view the arrangements in place in relation to the use of this, however, this was not available within the designated centre. The inspector was informed this was held in another department and this information would be sent to the inspector following the inspection. The inspector did receive a document outlining the use of this vehicle which was signed by the resident and staff members, however, the document was dated three days after this inspection. The inspector was very concerned given information submitted by the provider to HIQA regarding the management systems in place for residents finances.

Judgment:

Non Compliant - Major

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

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

Findings:

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

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

Resident's individual communication requirements were highlighted in residents' personal plans. The communication section provided essential information on supporting residents to communicate and assist staff members to engage with residents. From the sample of four communication profiles viewed some of these included specific phases residents used to communicate their needs effectively to members of staff.

Over the two days the inspector observed staff members communicating with residents in accordance with their assessed communication needs.

Judgment:

Substantially Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

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

The inspector spoke with staff members, residents and met with two family members.

Family members were encouraged to get involved in the lives of residents in accordance with residents' preferences. Family members could and did visit the designated centre

on a regular basis. Residents had pictures of family members in the centre.

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

Judgment:

Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

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

Findings:

The centre had a policy on admission which outlined the arrangements in place for admitting and transferring residents within the centre. This document was in draft format within the centre, however, the provider nominee identified this policy had been approved and provided the inspector with a copy.

The inspector viewed a sample of six contracts of care and found that each resident had a contract of care in place. However, the contracts did not outline the services to be provided and all of the fees to be charged. The provider nominee identified during the feedback session that the organisation was currently in the process of reviewing the contracts of care.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

Theme:

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

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

Findings:

Residents did not have the opportunity to participate in meaningful activities that were appropriate to their interests and preferences. In addition, staff members were not guided effectively as some residents did not have up-to-date personal plans in place.

The inspector requested to view four specific residents' personal outcome assessments with the annual plans within one house. These were not available for 2017. In another house, the inspector requested to view three resident's assessments and plans. These were also not available for 2017, 2016 and one resident had a plan in place dated 2015. The resident informed the inspector that they had achieved the goals set in the plan; however, no goals were identified since these goals were achieved in 2015.

The inspector was informed two residents did not have social plans in place as they were under the palliative care team. The inspector requested evidence where the decision was made for these residents to no longer have a personal plan outlining social goals and activities. This information was not available, within the centre.

The inspector viewed documentation in relation to activities and outings and found one resident did not participate in any activities outside the campus in the evening times since January 2017. The inspector spoke with a staff member to ascertain if the documentation was accurate or if there was a reason why the resident was not engaging in activities during the evening. The inspector was informed the resident most likely did not participate in activities during the evening outside of the campus. Another staff member identified the lack of social outings was due to the assessed needs and preferences of the resident. Yet, this was not reflected within the resident's file. Other staff members identified activities could not be facilitated due to the shortage of staff members.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

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

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

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The systems in place to promote the health and safety of residents, visitors and members of staff required significant improvement. Areas were identified in relation to the management of risk and fire during this inspection.

There were systems in place for the prevention and management of fires. Certificates and documents were not present on the day of inspection to show the fire alarms, emergency lighting and fire equipment were serviced by an external company as required by regulations. The inspector requested this information be sent into HIQA following the inspection. The procedures to be followed in the event of a fire were displayed in a prominent place. The procedure for evacuating residents at night in some houses required the assistance of ten members of staff, this could potentially result in some houses having no members of staff present while evacuation was occurring in another area. The inspector received confirmation for the provider nominee via email that this procedure was approved by an external fire consultant. Some staff members spoken with were unclear in relation to what the process was within the designated centre at night if the fire alarm sounded. The inspector viewed evidence that fire drills were taking place in the centre.

The centre had a policy on the management of risk. The centre did not have a risk

register in place outlining the risks in the centre and the controls in place to manage the risks. Individual risk assessments for residents were not maintained up-to-date, for example, staff informed the inspector a resident was a high risk of leaving the house without staff members. The inspector viewed the risk assessment in place, however, this outlined the resident was not at risk of this and had a rating of zero. The person in charge identified this was not accurate and the risk management system in place in the centre had yet to be completed and did not currently guide practice.

The centre had infection prevention, and control procedures in place. The inspector observed personal protective equipment and hand hygiene facilities were available in the centre. However, some of the practices within the centre did not promote effective infection prevention and control measures. For example, one staff member was in the toilet area and then entered the kitchen and proceeded to participate in food preparation. The inspector asked the staff member if they have changed their protective equipment, however, this was not completed. The staff member then removed this item of equipment and performed hand washing before proceeding with meal preparation. The inspector also observed one sharps container had no label or tagging system used for identification purposes.

The centre had an up-to-date health and safety statement in place. This outlined the responsibilities of the various staff members within the organisation.

Judgment:

Non Compliant - Major

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):

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

Findings:

There were appropriate measures in place to protect residents from being harmed and to keep people safe. Improvements were required in relation to chemical and environmental restrictions and the management of residents finances.

The inspector found intimate care support plans were in place, however, these were not guiding practice and did not contain sufficient detail to maintaining the dignity of each

resident.

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

Guidance for staff in relation to behaviours that challenge could not be found on the day of inspection for one resident. The resident's file contained a handwritten note dated March 2017 "plan taken for photocopy". This document was not available within the centre to guide staff members in the management of this resident's behaviour.

Staff members identified environmental restrictions were in place for this resident in the form of locking the outside door. The inspector was informed this occurred when the level of staff members was reduced to two members. The inspector requested to view the rationale for the locking of the door and the review process in place by the restriction committee. On the day of inspection no documentation was present identifying when this was approved or when this was reviewed. The inspector requested evidence of the previous approval for this restriction to be sent in to HIQA following inspection. This information was not submitted. The inspector viewed a recording log for 2016 and 2017 for this restriction. From the records viewed the doors were locked some days for up to seven hours during the day. The inspector requested to view the review of this practice, however, this not available. The inspector found the recording log which consisted of a tick box recording method which did not facilitate accurate recording of this restrictive practice.

There was no procedure or guidance available within the house to effectively and consistently guide this practice. The inspector was informed this was in operation for a number of years. However, the inspector was unable to see any alternatives implemented or how and what the impact of this restriction had on other residents living within the house.

An observation tool was in use for one resident in relation to specific behaviours. However, staff members were also not guided in relation to what these behaviours were nor was there evidence of any trending of these behaviours. From viewing the records available four of the six previous recorded incidents were documented when unfamiliar staff were present in the house and two of the six recorded incidents occurred when the house was busy. The inspector observed the resident displayed some of the specific behaviours on the day of inspection, yet, the observation tool was not completed. Staff were not guided in relation to the use of this tool in terms of the duration of the observation period.

The inspector also viewed a plan in place for one resident in relation to accessing the restaurant at lunch time. This document was dated 03 July 2015 with no evidence of review. The document stated " direct resident away from ladies in the restaurant and in the surrounding area". The inspector was unclear why this plan was in place, particularly when staff members in the house providing care to this resident were mostly females. The person in charge identified this plan should not be in place. The inspector found this

was not based on any assessed need nor was this guiding staff in the centre in relation to the provision of care for this resident. The inspector identified this centre was heavily reliant on relief and agency staff members.

Chemical restraint in the form of prescribed PRN (a medicine only taken as the need arises) medicine to alter residents behaviour was used within the centre, however, there was no guidance available to staff members in the implementation of this for one resident.

The inspector spoke with members of staff and they were clear in relation to what was the procedure should an allegation of abuse arise within the designated centre. One staff member on the second day of inspection was unclear in relation to the different forms and types of abuse. From viewing a sample of training records for 46 members of staff, six members required refreshing training in the area of the prevention, detection and response to abuse. Five staff members required training in behaviour de-escalation techniques and 21 staff members required refresher training.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

A record of all incidents occurring in the designated centre was maintained and where required, notified to the Chief Inspector. The person in charge was aware of the legal requirement to notify the Chief Inspector.

Judgment:

Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Residents had very limited opportunities for new experiences and social participation.</p> <p>In the main social activities were provided by day services with very limited social activities facilitated by the designated centre.</p> <p>Residents attended day services and some residents had retired from their day services. One resident met with the inspector and outlined their dissatisfaction in relation the provision of their personal assessment as the resident did not receive this service for a number of weeks. The resident was not made aware of what developments had occurred in relation to this.</p>
<p>Judgment: Substantially Compliant</p>

<p>Outcome 11. Healthcare Needs <i>Residents are supported on an individual basis to achieve and enjoy the best possible health.</i></p>
<p>Theme: Health and Development</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Significant improvements were required to ensure residents assessed healthcare needs were met. The inspector issued an immediate action to the provider nominee on day one of the inspection in relation to the provision of food. The inspector received written assurance from the provider nominee in relation to interventions put in place to mitigate the risk of this re occurring.</p> <p>On the first morning of inspection, the inspector observed one resident received their breakfast. This resident was not provided with the appropriate feeding utensils nor was this resident supervised as outlined in the feeding eating drinking swallowing (FEDS) guidelines. The inspector observed the resident for 25 minutes, during this time the resident did not eat any food. The resident made movements of raising food to their mouth, however, the food did not reach the resident's mouth. Another member of staff entered the kitchen and removed the breakfast from the resident and placed this in the bin and proceeded to make a cup of tea for this resident. The inspector informed the</p>

staff member that the resident had not eaten any of the breakfast. The inspector also asked if an alternative breakfast option would be offered to the resident. The staff member identified that the resident did not really eat breakfast and that there was nothing else such as, bananas to offer the resident, as the shop was due into the centre tomorrow. The resident subsequently left the centre that morning without receiving any food. On speaking with one relief staff member they identified they would inform the day service of this issue and see if the resident would eat something in the day service. The inspector found the lack of a person-centred approach to this very basic provision of food was not appropriate. This was further compounded by the fact that staff members had access to a canteen facility within the campus and food items could be sourced there if not available within the house.

On the second day of inspection, the inspector went back to the same house to observe if the measures outlined by the provider nominee were in place. The resident was observed with their breakfast and the incorrect feeding utensils again, the person in charge did address this issue.

Residents requiring modification to the texture of their food had this information outlined in the residents' files. The inspector viewed FEDS guidelines in place for some residents, however, as outlined above some staff members were not familiar with these. Over the course of the two days the inspector observed members of staff standing up while feeding residents their meals within the living areas of the house. The inspector found this practice inappropriate and did not demonstrate respect towards residents. Seating was available for staff members to sit and maintain eye contact with residents while feeding residents their meal in a more relaxed atmosphere.

The healthcare needs of residents' were completed via a plan incorporating nine areas of assessments. These included, communication, breathing and circulation, nutrition and hydration, continence and elimination, personal care, meaningful activities and sleep and rest. The inspector viewed six healthcare plans and found some of these required improvement to ensure medical treatment recommended for residents were implemented and healthcare needs were met. Areas identified included:

- some assessments viewed in relation to nutrition, contained inconsistent information for example, level of assistance required was blank. The resident was also not identified with swallowing difficulties. However, the resident's FEDS guidelines stated the resident was a "high risk of choking" and required a modified diet. The inspector found these documents were not directing care to meet the assessed needs of residents. In addition staff members were not guided effectively to ensure some residents received the required healthcare provisions particularly as this centre was reliant on relief and agency staff members on a daily bases

- the management of healthcare conditions, such as, gastrointestinal issues were not outlined within some resident's assessments. However, the resident was prescribed medication for this issue. Other areas in relation to elimination needs for residents were not clearly outlined in residents' plans to ensure consistent and effective care delivery in accordance with residents assessed needs

- interventions outlined within some residents plans were not updated annually and

other plans of care contained no date or review of the interventions in relation to the effectiveness of the treatment provided

- one epilepsy management plan viewed contained no date, with no evidence of review to ensure the resident's healthcare treatment was suitable to meet the current needs of the resident

- the review process in place for areas identified required improvement to identify the effectiveness of the interventions implemented to ensure these were having a positive impact on resident's healthcare needs.

Advanced care directives were in place for two residents, the inspector viewed one dated November 2016. The resident had been reviewed regularly by a clinical nurse specialist. The resident was clear in relation to where they wished to receive their care and outlined their preference to remain within their home in the centre.

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

Judgment:

Non Compliant - Major

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

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

The inspector viewed some administration sheets and found some medication prescribed as a PRN was not administered as prescribed, this was highlighted to staff members on the day of inspection.

The inspector found some PRN medicine did not have the maximum dosage stated for a 24 hour period. Staff members were not clearly guided in the administration of some PRN medicine. For example, a resident was prescribed the same medication in three different formats, yet, staff members were not guided in relation to when to administer what format and what was the maximum dosage of the medicine was for a 24 hour period.

Two other PRN medicines did not have the name of the resident contained on the medication. The inspector also viewed PRN medicine contained in a plastic bag with an expiry date for April 2015. The inspector checked the actual medication which stated 2021. The inspector found the practice of placing new stock into storage bags of old stock was not effective practice in medication management.

The inspector requested to view the records of the rescue medication leaving the centre, however, staff members identified no record was maintained.

In one house, the inspector observed the keys of the medication press remained in the press with the press unlocked while staff administered medication in another room. The inspector also observed medication was not disposed of in accordance with the organisations policy during one medication round.

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

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

There was a system in place for recording, reporting errors and reviewing medication. The inspector viewed incidents which occurred within the designated centre, however, there was no evidence of learning from some of these incidents to mitigate the risk of future reoccurrences.

The inspector found the signature bank within the designated centre was completed.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The details contained within the statement of purpose in relation to the information set

out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 was not reflective of practice within the centre. Areas included:

- the number, age range and gender of residents for whom it is intended that accommodation should be provided
- the total staffing complement, in full-time equivalents, for the designated centre with the management and staffing complements as required in Regulation 14 and 15
- the arrangements made for dealing with reviews of a resident's individualised personal plan.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Significant improvements were required in the area of oversight of this centre to ensure safe, consistent and effective delivery of care in accordance with residents needs. This was evident through the findings of this inspection within the outcomes inspected and the level of non-compliances identified.

The inspector found the management structure in place did not have clear lines of authority, roles and accountability among the layers of management within the designated centre. Therefore, the management of the designated centre did not ensure the quality and safety of the provision of services in a consistent manner to the residents within the centre. The person in charge for this centre was also required to manage another designated centre at times. There was no evidence of meetings occurring between these managers to ensure care directed was done in a consistent manner. Some staff members spoken with identified they would take direction mostly from managers from the other designated centre as the person in charge of this centre

was not working on the same roster line as them.

For this centre the person in charge was supernumerary to the rota and was supported by one clinical nurse one manager who was also supernumerary. There was a second clinical nurse one manager's post vacant on the day of inspection. Both the person in charge and the clinical nurse managers reported to a clinical nurse manager three who were also supernumerary, on the day of inspection this post was also vacant.

The inspector viewed minutes of staff meetings within the designated centre, however, these were not conducted regularly and were completed within each house. No staff meetings took place from a centre based perspective, despite staff moving from house to house. The inspector was unable to view any management meeting including the person in charge and the clinical nurse managers to ensure a consistent approach to the delivery of services. The inspector acknowledged the person in charge did attend some staff meetings within houses, however, this was not consistent across the four houses. The inspector was also unable to view any evidence where the service provided in the centre was discussed in terms of residents safety and residents' needs to ensure all members of staff were implementing care in a consistent approach. Instead limited individual meetings were held with various members of staff in relation to residents needs.

The inspector found the monitoring of the service provided was not effective as limited audits in relation medication and residents finance were conducted. However, these audits did not identify some basic fundamental findings which the inspector identified during this inspection. In addition, the quality of service delivered to residents in relation to health and social care was not audited from a centres perspective.

Effective arrangements to support, develop and performance manage all members of the workforce was not occurring within the centre. The centre had a yearly performance appraisal system in place, yet, this was not being implemented effectively. The inspector viewed a sample of five staff members performance appraisals. None of these staff members had plans completed in 2017. Some documents viewed were blank templates with no follow-up evident. The inspector identified this did not facilitate staff members to exercise their personal and professional responsibility for the quality and safety of service they provided within the centre.

The provider had carried out an unannounced visit on a six monthly-basis in 2016 in this centre and one in April 2017. An action plan was developed with timeframes and people to carry out these actions, however, some of these actions remained uncompleted on the day of inspection despite a timeframe for August on the action plan in relation to risk management for example.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the

designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

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

Judgment:

Compliant

Outcome 16: Use of Resources

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

Theme:

Use of Resources

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

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

Findings:

The centre was resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

The centre did not always have sufficient staff numbers with the right skill mix, qualifications and experience to meet the assessed needs of the residents. Some of the rotas viewed were also not reflective of practice.

Overall, the inspector found significant improvements were required to ensure continuity of care to residents and ensure negative outcomes for residents were not occurring due to lack of regular familiar staff members. The inspector identified from viewing the proposed and actual staff rota and significant gaps were present. The centre was heavily reliant on relief and agency staff members. The inspector found several days where relief and agency staff members were working within the centre instead of regular staff members. The inspector also viewed days where required shifts were blank for the following week. The inspector observed residents asking what staff members were working in their home the following day, however, in some houses staff members were not able to provide residents this information. Staff members present in the centre during the night were not fully reflected on the rota, as staff members identified that a member of staff would work between some houses at night. In one house the inspector also identified the rota present was for the previous week was incorrect, during the inspection the correct version was sent to the house.

From speaking with staff and viewing the rota the designated centred was not operating as one designated centre. This was evident as staff members within two houses were not aware that four houses made up the designated centre.

The inspector found that staff resources were not organised in a way to meet the assessed needs of residents. For example, on the second day of inspection the staff numbers during the morning of the inspection were three in one house. The inspector was informed this was the required number of staff members for the morning time. However, from observation this was not sufficient, as two of the three members of staff were relief. Due to an immediate action issued, the person in charge was also present to observe. The inspector observed that the person in charge actively participated and directed the provision of care. Some residents waited at the table for long periods of time to receive their breakfast and one member of staff stayed in the centre 30 minutes longer than rostered to attend to residents needs. From this the inspector determined staffing was not organised in a manner to effectively meet the needs of residents in a person-centre approach.

The inspector identified that no supervision was taking place, for example, a record was maintained, however, this had entries for June and September 2017 relating to conversations in relation to annual leave. The inspector highlighted this to the person in charges, as this practice was not ensuring staff members were supervised. Staff members spoken with identified they had not received supervision.

From viewing 46 members of staff training records, one member of staff required

training in the area of people moving and handling and eight staff members required refresher training. Six staff members required refresher training in the area of fire safety.

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

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

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

Schedule 5 policies for the centre had been submitted into HIQA before this inspection. The staff training and development policy was in draft format dated 2017 and the revised admissions policy was not available within the centre.

Some of the Schedule 4 documents were not available within the designated centre on the day of inspection in relation to the records of testing of fire equipment including fire alarm equipment and any action taken to remedy any defects found in the fire equipment.

Overall, the inspector found the retrieval of some schedule 3 documents was difficult, and in some instances, documents were unavailable, out of date or blank within residents files.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004926
Date of Inspection:	21 September 2017
Date of response:	4 December 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The designated centre was not operated in a manner that respected the age, gender, disability and civil status of each resident. This was evident through the routines and practices observed during both mornings in relation to the provision of personal care and mealtime assistance.

1. Action Required:

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

Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

The EDS guidelines of residents in each house will be evaluated and updated in accordance with the resident's current needs, preferences and choice. The CNM in collaboration with the SLT department assigned to the house will be responsible for this review and update.

Breakfast/Morning supervision commenced where assigned DC3 manager will oversee morning routine and supervise staff to ensure all nutrition and hydration needs of residents are adequately met 22.9.17 x 1/12, then appointed breakfast supervisor of the day and to write clearly under safety huddle/pause section of task allocation sheet. Each house has a dedicated CNM 1 and this CNM1 will spend a minimum of 19.5 hours weekly present between their assigned houses supervising and mentoring staff.

Proposed Timescale: 22/12/2017

Theme: Individualised Supports and Care

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

Evidence that each resident participated in and consented, with supports where necessary to decisions about his or her care and support to funding medical procedures and other items such as, household and food products was not available within the centre.

2. Action Required:

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

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

Long stay contribution form to be filed in financial section of Personal file, with a copy of Appendix 1 Memorandum of Understanding/Contracts of care in each ledger. The costs incurred by a resident for a medical procedure (ECG) will be addressed by the PIC with the resident's family members. A record of the consultative process and agreement reached will be kept in the resident's personal file in the financial section along with a record of any monies refunded to the resident.

The costs incurred by a resident for food items to be reimbursed to the resident and resident consulted about same. Copy of Appendix 1 Memorandum of Understanding/Contract of care to be placed in each resident's financial ledger to guide what costs are covered by Cheeverstown and therefore protect the rights of residents. DC3 CNM1, CNM2 carried out financial meetings with staff in DC3. Financial Policy signature of all staff, read, understood and signed for each house in DC3.

Proposed Timescale: 22/12/2017

Theme: Individualised Supports and Care

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

A. Each resident's privacy and dignity was not respected in relation to, his or her personal and living space, intimate and personal care.

B. Some residents entered each other's bedrooms and various people entered into the home of residents without knocking or ring on the door bell.

C. The practice of staff members entering some resident's bedrooms during the night to complete regular checks was not promoting the privacy and dignity for residents. The rationale for this practice was not evidenced based on the assessed needs of residents.

3. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

Intimate care plans to be updated to include who wears slipper, dressing gowns etc

Photograph of each resident placed on each of the residents bedroom doors to support staff redirecting residents to their own personal space

Each house will be respected as the home. Staff will ring the doorbell before entering.

The manager or identified lead staff on shift will be responsible to highlight staff not compliant showing this respect so that this can then be followed up with individual staff members under performance management.

Managers/PIC to consult with night staff to commence review for individuals to ensure the rationale for night checks relates directly to individual needs assessments of residents. This will be documented on individuals support document including risk assessment and clearly outlined under Night duty procedures document.

Proposed Timescale: 22/12/2017

Theme: Individualised Supports and Care

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

The complaints log present in the centre contained one complaint from June 2016 and another complaint remained within the resident's file without going through the complaints process.

4. 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:

The Centre's Complaints Log will be reviewed and any remaining outstanding issues will be addressed. Any resolution or feedback discussions on complaints will be recorded. Any outstanding complaints to be addressed in Local Complaint log and addressed by PIC. If there are complaints that are unresolved, the PIC will meet with the resident again to address the complaint and feedback.

Proposed Timescale: 04/12/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Resident's did not have access to the internet within their homes in the centre.

5. Action Required:

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

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

The IT manager has secured some funding to upgrade the internet access for locations in DC3. Once the cable is in place we expect TV reception to be accessed through android boxes. Priority will be given to locations within DC3 for improved TV reception.

Proposed Timescale: 01/12/2017

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

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

Supports to develop and maintain personal relationships and links with the wider community in accordance with the wishes of residents were very limited.

6. Action Required:

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

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

Each resident's social care plan will be reviewed with them by the nominated CNM1 to

the house and/or key worker to ensure all their individual social care needs are assessed and the appropriate level of support is given. Meaningful activities specific to the individual will be identified. Each person's plan will be updated and documented to reflect the person's wishes.

Social Needs and links to the community to be placed on the residents meeting's agenda.

The staff roster will be reviewed to help identify staff to support individual community links and personal relationships.

Proposed Timescale: 20/02/2018

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Some written agreements were not up-to-date to reflect the provision of services including the support, care and welfare of the resident and details of the services to be provided for that resident and the current fees and additional charges.

7. Action Required:

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

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

Financial Assessments of care are being completed and awaiting contracts, stipulating the provision of service for each individual.

Proposed Timescale: 22/12/2017

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:

Evidence of a comprehensive assessment, by an appropriate health care professional, of the social care needs of each resident was not available within the centre.

8. Action Required:

Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.

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

Full and comprehensive Needs Assessments has commenced for each service user in the DC through an MDT approach.

Proposed Timescale: 01/02/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Personal plans from a social care perspective which reflected resident's assessed needs were not completed.

9. 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:

Full and comprehensive Needs Assessments to be completed for each service user in the DC through an MDT approach.

Some staff have received refresher training on meaningful activities assessment tool which is currently underway with individuals, their family, staff & manager.

Proposed Timescale: 01/02/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents' personal plans viewed were not reviewed annually or more frequently if there was a change in needs or circumstances.

10. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

All Care plans to be reviewed and updated annually or as and when is necessary.

Proposed Timescale: 20/01/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

Personal plan reviews did not assess the effectiveness of each plan and take into account changes in circumstances and new developments for residents as these were not occurring within the designated centre.

11. 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:

The personal plans of residents in each house will be evaluated and updated in accordance with the resident's current needs. The review of the plan will assess the effectiveness of the plan to ensure it is meeting the agreed goal. The CNM assigned to the house will be responsible for this review and update.

The personal plans of residents will guide staff in their daily practice and their support of residents. If a staff is unfamiliar with the current needs of the resident, the CNM or lead staff in the house will direct the staff member to the personal plan before they support the resident.

Staff have received refresher information on how to evaluate effectively.

Proposed Timescale: 01/02/2018

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 system in place in the designated centre for the assessment, management and ongoing review of risk from either a centre or resident perspective.

12. Action Required:

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

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

A planning meeting was held with the PIC and clinical nurse managers on 8th November 2017 for a full review of the risk management systems in designated centre 3 from both an individual and centre perspective. A plan is active to address noncompliance with Cheeverstown Risk Policy-

Each resident will have a review and update of their individual risk assessments. Each house will have their Risk Register reviewed and updated. There is a process to escalate risk to the Corporate Risk Register if required. The PIC is responsible for ensuring the process is followed.

Staff training on risk assessments for DC3 is arranged for Friday 10th and Tuesday 14th November 2017 facilitated by the Risk Manager

Two frontline staff in each house in DC3 will be identified as "Risk Champions" and they will liaise with the Risk Manager, PIC and CNM1's to complete a full review and update of all individual risk assessments, Individual Safety Plans and Risk Registers for all houses in designated Centre 3 to be completed by Friday 8th December 2017. Documentation and certificates pertaining to fire safety of houses in the designated centre are now held in the manager's office and in all the houses. The night time fire evacuation plan for DC 3 has been reviewed with the night managers and the health and safety officer. There will be additional simulated fire drills in DC 3 over the next 4 weeks to address the knowledge deficit of staff. These fire drills will include day and night evacuation plans. Fire evacuation drill procedure is included at the start of the morning handover in the safety pause.

Proposed Timescale: 11/12/2018

Theme: Effective Services

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

Observed practices within the designated centre did not ensure infection prevention and control measures were effectively implemented in relation to personal protection equipment and the management of sharps.

13. 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:

Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with standards for the prevention and control of healthcare associated infections published by HIQA and Cheeverstown Infection Prevention & Control policy. Refresher training will be provided for staff on topics such as Hand hygiene, waste management and use of PPE's.

Hand hygiene audits will be included on the schedule of clinical audits for each location

Proposed Timescale: 15/01/2018

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 members did not 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 and resident's plans were not guiding practice.

14. 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:

Staff have initiated a multidisciplinary review for individuals of positive behavioural supports and interventions to ensure that all client needs are identified with a plan of intervention that guides staff practice.

Staff who work and support individuals with positive behaviour support needs have been prioritised for attendance at training.

Proposed Timescale: 30/01/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

From viewing a sample of 46 members of staff training records, five staff members required training in behaviour de escalation techniques and 21 staff members required refresher training.

15. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

8 staff are booked for MAPA training on December 7th and 4 staff are booked for December 13th 2017. The remaining staff will be booked for the first available date in 2018. Date not currently confirmed with staff training & development department.

Proposed Timescale: 30/01/2018

Theme: Safe Services

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

Some chemical and environmental restrictions used, they not applied in accordance to evidence based practice.

16. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in

accordance with national policy and evidence based practice.

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

There will be a review of environmental restraints used in each house. If the restraint is required and evidence based, the documentation and reasoning behind the restraint in use will be clearly evident in the individuals care plan. The PIC is responsible for this action.

A multidisciplinary team will review the 'locked door' environmental restriction for the resident and the review process will be recorded.

Positive Behavioural Support Plans will be reviewed in conjunction with the multidisciplinary team. The care plan will be revised to guide staff on measures to take to manage behaviours and de-escalate a situation. The plan will also guide staff to recognise an escalation in behaviours and the appropriate intervention to take. All proactive and reactive strategies will be documented by the staff providing support to the individual.

A 'prn protocol' will be developed and staff will use this to give them a direction of when to intervene and what intervention to use, this will give guidance to ensure a consistency approach to care delivery.

Proposed Timescale: 18/12/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A. Evidence that every effort to identify and alleviate the cause of residents' behaviour was not evident.

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

C. Evidence that the least restrictive procedure, for the shortest duration necessary, was implemented was not evident.

17. 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:

Staff have initiated a multidisciplinary review for individuals of positive behavioural supports and interventions to ensure that all client needs are identified with a plan of intervention that guides staff practice.

Any intervention plan that is assessed as requiring a restrictive practice will do so only as a measure of last resort be the least restrictive for the shortest duration possible.

Documentation has been revised to clearly outline the purpose of the restrictive measure, the duration in place and the communication with the staff and resident.

Proposed Timescale: 15/12/2017

Theme: Safe Services

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

Effective control measures were not in place to ensure residents were protected from financial abuse.

18. Action Required:

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

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

Issues relating to financial abuse are covered in Cheeverstown Adult Safeguarding Policy & procedure. Safeguarding training for staff identifies finance as a category of abuse. Any confirmed incidents of financial abuse will automatically be reported to the authorities including the guards.

Finance department alongside PIC & managers are working through a schedule of audits for each resident. If identified, through the audits, any inappropriate expenditure of an individual's personal monies will be calculated and refunded.

Clear guidance for staff has been circulated to guide staff on what it to be funded through Cheeverstown budget and what is to be funded personally.

Proposed Timescale: 22/12/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some intimate care plans were not guiding practice to ensure resident's dignity and bodily integrity was respected.

19. 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 & Intimate care plan reviews have commenced to ensure they reflect the persons individual needs and guide staff practice with respect & dignity.

Proposed Timescale: 22/12/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

One staff member was unclear on what constituted abuse.

Some members of staff required refreshing training in area of safeguarding residents and the prevention, detection and response to abuse.

20. Action Required:

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

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

Six staff completed Safeguarding training on November 6th. Five staff are booked to attend Safeguarding training on December 14th 2017.

Cheeverstown Designated Officer will attend staff meetings during December 2017 to support the learning by staff at training.

Proposed Timescale: 14/12/2017

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Limited opportunities for education, training in relation to social activities was evident within the centre for residents.

21. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

Staff are working with individuals and their families to ensure all people have opportunities for new experiences, social participation, education, training and employment. Rosters will be redesigned to ensure staff can facilitate and support all opportunities.

Proposed Timescale: 11/12/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Appropriate healthcare for each resident, having regard to each resident's personal plan was not evident within some plan viewed.

22. Action Required:

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

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

Each resident's health care needs will be reviewed and reassessed to ensure that appropriate supports are in place for each individual.

Proposed Timescale: 02/02/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some medical treatment recommended for residents was not facilitated.

23. 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 resident's health care needs and timely access to health care services will be facilitated by staff in the designated centre.

Proposed Timescale: 27/12/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents who required assistance with eating or drinking, were not provided assistance in an appropriate manner as detailed within the report.

24. Action Required:

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

All individuals FED's plans have been discussed at staff meetings and are included as an item on the staff handover meeting.

All supports required for individuals including utensils are documented and available for individuals.

Proposed Timescale: 01/12/2017

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 provided with adequate quantities of food and drink which offered choice at mealtimes as identified within the report.

25. Action Required:

Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

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

A plan is in place to ensure there is appropriate supervision at all mealtimes. Included in the supervision is the appropriate implementation of each person's eating drinking swallowing guidelines to ensure meals and choice are available at times suitable to the person. SLT department have been requested to provide FED's training for staff around individual care needs.

Proposed Timescale: 18/12/2017

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:

The keys of the medication press remained in the press with the press unlocked while staff administered medication in another room.

26. 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:

Cheeverstown Policy & procedure for medication management is an agenda item for staff team meetings. Failure by staff to follow the policy and procedure will be addressed by management and PIC under performance management and a performance improvement plan will be put in place as necessary. Staff nurses are scheduled to complete medication management elearning module on hseland Pharmacist will complete local briefing with nursing staff.

Proposed Timescale: 12/12/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some medication prescribed as a PRN was not administered as prescribed.

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

Two PRN medicines did not have the name of the resident contained on the medication.

Medication was not disposed of in accordance with the organisations policy during one medication round.

There was no evidence of learning from some of these incidents to mitigate the risk of future reoccurrences.

27. 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:

Each person's kardex in DC3 will be reviewed with the prescriber and pharmacist and updated to include maximum dosage within a 24hour period. One location is completed 14/11/2017. Other residents are included in a schedule to be completed.

All medications stored within each location will be clearly labelled as per policy.

Medication error reviews will be included at staff team meetings to ensure learning and minimize the risk of reoccurrence at local level.

Summary medication error reports now included on each House Risk Register will facilitate local reviews

Medication management subgroup will now report to the Quality, Safety & Risk Committee in relation to shared learning from reviews of medication errors at an organisational level

Serious medication error incidents can be escalated to the Corporate Risk Register as required

Proposed Timescale: 16/12/2017

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:

The statement of purpose did not accurately reflect 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 for the designated centre.

28. 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:

The statement of purpose and function will be updated to ensure the age range of persons supported is accurate and the document reflects the staffing compliment and arrangements for review of personal plans.

The updated document will be circulated to all 4 locations.

Proposed Timescale: 27/11/2017

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:

A clearly defined management structure that identified the lines of authority, accountability, roles, and responsibility for all areas of service provision was not evident within the centre.

29. 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:

The PIC to DC 3 is supernumary to the roster and primarily working Monday to Friday. The CNM3 manager is the PIC and is directing governance at this time to ensure effective systems are in place that support and promotes safe services.

The PIC is supported by 2 whole time equivalents CNM1's.

The CNM 1's are assigned to the houses within the designated centre and have specific roles to that nominated house.

The dedicated CNM1 accountable for a house (s) will spend a minimum of 19.5 hours weekly giving direct supervision and mentoring staff.

The manager will be present in the houses for 80% of their shift.

Roles within the management team will be clearly defined. Management team meetings for DC 3 will be held monthly.

Proposed Timescale: 29/12/2017

Theme: Leadership, Governance and Management

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

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

30. Action Required:

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

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

The PIC to DC 3 will be supernumary to the roster and primarily work Monday to Friday.

The PIC is supported by 2 whole time equivalents CNM1's. The CNM1s are leads in assigned houses.

The CNM 1's have specific roles to that nominated house.

The dedicated CNM1 accountable for a house (s) will spend a minimum of 19.5 hours weekly giving direct supervision and mentoring staff.

The manager will be present in the houses for 80% of their shift.

Proposed Timescale: 29/12/2017

Theme: Leadership, Governance and Management

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

Effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering was not taking place.

31. Action Required:

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

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

A schedule for individual annual staff performance management meetings is arranged with the goal to ensure all staff have an opportunity to be an effective responsible staff member. This will commence in December 2017 and projected 4 months for full completion.

Proposed Timescale: 15/12/2017

Theme: Leadership, Governance and Management

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

Staff members were not facilitated to raise concerns about the quality and safety of the care and support provided to residents as some staff members were directed by managers from outside this centre.

32. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

When the roster review and change with frontline staff is completed the CNM1/PIC roster will be altered to ensure effective supervision and support to all staff the DC.

Proposed Timescale: 29/12/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staffing levels was not organised in accordance with the assessed needs of residents.

33. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

A roster review is commencing to reflect the assessed needs of the residents. The purpose is to ensure that there are appropriate staff numbers and skill mix to meets the needs of the residents and provide for continuity of care.

Proposed Timescale: 17/12/2017

Theme: Responsive Workforce

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

Residents were not receiving continuity of care and support due to the level of relief

and agency staff members required to operate the centre.

34. 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 purpose of the roster review is to ensure that there are appropriate staff numbers and skill mix to meet the needs of the residents and provide for continuity of care. The review will include the supports for residents provided by our core support team and they will have a consistent assignment.

Proposed Timescale: 29/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The rota in one house was not up-to-date.

The rotas within the centre did not reflect all members of staff working in the centre over a 24-hour period.

35. 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 roster is printed and available for each location two weeks in advance. Managers will update same on a weekly basis and all staff providing support to the house over the 24hr period are named on roster.

Proposed Timescale: 29/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some of the information as specified in Schedule 2 were not present in staff files..

36. Action Required:

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

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

HR department has completed a full audit on staff files for designated centre 3 and all

missing schedule 2 documents have now been put on file.

Proposed Timescale: 01/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some staff members required refresher training in the area of fire safety and people moving and handling.

37. Action Required:

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

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

Four staff have completed safe moving & handling on 5th of November and one staff is booked on the 5th Dec 2017

Two staff have completed fire safety training and four staff are booked for the 4th December.

Proposed Timescale: 05/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff members were not appropriately supervised.

38. Action Required:

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

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

CNM1's are assigned to locations and will be included on the roster to ensure supervision for staff.

Proposed Timescale: 04/12/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

The staff training and development policy and the admissions policy was in draft format dated 2017 within the centre yet, the admission policy had been approved by the board.

39. Action Required:

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

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

All schedule 5 policy folders have been audited and all out of date policies are in the process of being removed and replaced with the current policies. A communication implementation plan for the policies will commence 5th December.

Proposed Timescale: 05/12/2017

Theme: Use of Information

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

Some of the Schedule 4 documents were not available within the designated centre on the day of inspection in relation to the records of testing of fire equipment including fire alarm equipment and any action taken to remedy any defects found in the fire equipment.

40. Action Required:

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:

Originals of schedule 4 documents are held with the health & safety officer. All designated centres will hold a copy of all documents.

Proposed Timescale: 05/12/2017

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, and in some instance, documents were unavailable, out of date or blank within residents files.

41. Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of

the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

All residents' files are in the process of being audited to ensure schedule 3 documents for each person are available and accurate. Any missing information or documents will be replaced and updated.

Proposed Timescale: 18/12/2017