

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Centre 3 - Cheeverstown House Residential Services (Active Age/Senior Citizens)
<b>Centre ID:</b>	OSV-0004926
<b>Centre county:</b>	Dublin 6w
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Cheeverstown House Limited
<b>Lead inspector:</b>	Karina O'Sullivan
<b>Support inspector(s):</b>	Julie Pryce
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	21
<b>Number of vacancies on the date of inspection:</b>	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:
18 January 2018 08:30	18 January 2018 17:30
19 January 2018 09:30	19 January 2018 15:00

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 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 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. At that time, this centre was not found to be in sufficient compliance with the regulations in order for the Chief Inspector to grant registration. Resulting from 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 persons in charge being assigned to centres. The provider responded by appointing persons in charge to each designated centre.

A further inspection took place over two days in September 2017. Significant breaches with the regulations were identified and an immediate action plan was issued on the first day of inspection, in relation to the provision of food to residents. Following the inspection HIQA issued the provider and the chairperson of the board with a notice of proposal to cancel and to refuse the registration of this centre on 01 December 2017. As a result HIQA received representation from the organisation on the 27 December 2017. This inspection was conducted to establish if the measures outlined in the representation plan and the action plan from the previous inspection were implemented and impacted positively on residents' lives. However, the finding identified that out of 41 breaches found in September 2017, 33 of these were also found in January 2018. Therefore, 82% of the breaches were repeatedly found. Inspectors did acknowledge improvements were occurring. These were at an early stage of implementation and required further time to become fully operational and thus come into compliance within the regulations.

How we gathered our evidence:

As part of the inspection, inspectors visited the four houses within the designated centre. Inspectors met 19 residents, one resident requested not to meet with inspectors and another resident was receiving treatment in an acute hospital. Inspectors spoke with three residents and three staff members over the two days. Inspectors viewed documentation such as, care plans, person-centred support plans, recording logs, policies and procedures.

Description of the service:

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

Overall judgment of findings:

Some changes had occurred since the previous inspection, yet, inspectors 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. However, five of the seven outcomes previously evidenced as major non-compliant had reduced to a moderate non compliance. As there were systems were now in place. At the time of the inspection these were not fully operational or effective in relation to enhancing the quality of lives of residents.

Fifteen outcomes were inspected against which resulted in 41 actions. Two outcomes were major non compliant, outcome 1: residents' rights, dignity and consultation and

outcome 5: social care needs. These areas required significant improvement to ensure residents' rights were upheld and effective systems were in place in relation to social care needs.

Out of the remaining 13 outcomes inspected against, seven outcomes were found to be in moderate non-compliance and six outcomes were substantially 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 the accompanying action plan.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Inspectors found two of the four actions identified by the provider following the last inspection had been implemented. These related to the operation of the centre in terms of respecting the centre as a home environment for residents. Consultation with residents which still required improvement and inspectors also identified some residents did not retain control over some of their clothes and possessions.

Inspectors acknowledged improvements in relation to respecting the privacy and dignity of residents. Inspectors observed staff members using door bells when they entered into the homes of residents. Inspectors also identified some practices in place which did not demonstrate that the dignity and privacy of residents were upheld. The laundry system in place was not effective in relation to residents' underwear as staff had no way of identifying what items belonged to what residents. Therefore, some clothing items once washed could be worn by another resident whom did not own the clothing.

Inspectors viewed residents' financial ledgers within the centre and found items identified during the previous inspection were refunded to residents. Inspectors were informed that some residents had purchased their own vehicle. Inspectors requested to view the arrangements in place in relation to this; these were not available within the designated centre. One inspector was informed that three residents had purchased a vehicle and that two of these residents no longer lived within the designated centre. The inspector then requested to view the written arrangement in place in relation to this, to ensure all three residents had access to their property. However, the inspector was then informed the three residents no longer owned this vehicle as it had been scrapped. The

inspector was subsequently was informed, the information provided was initially was incorrect and the vehicle was a donation and that the three residents did not purchase any vehicle. Due to the lack of clarity, inspectors then requested confirmation of all ownership of vehicles across the designated centres to be submitted to the Chief Inspector as similar issues had arose in other designated centres. Information provided identified two residents had purchased their own vehicle and two vehicles had been donated. The agreement was not clear in terms of the use of the vehicle. The document identified that fair distribution of the vehicle was the responsibility of the transport manager. Inspectors identified significant improvements were required in this area.

Inspectors found improvement was required in relation to consultation with residents. An inspector requested to view minutes of residents meetings within one house. No recent meetings had taken place. Inspectors also identified all grocery shopping took place online, yet, only one resident was identified as participating in this.

Inspectors viewed the complaints log and identified one complaint remained opened since June 2015. Both staff and residents had identified the issue remained outstanding and unresolved.

**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):**

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

**Findings:**

Inspectors found the action identified during the previous inspection was addressed in accordance with the actions provided by the provider. Residents had now access to the internet within their homes in the centre if they so wished.

Improvements were required in relation to training as staff had not been up skilled in the use of Lámh (manual sign system used by children and adults with intellectual disability and communication needs in Ireland). This impacted on staff members ability to wholly communicate with residents in a consistent manner.

**Judgment:**

Substantially Compliant

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**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):**

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

**Findings:**

Inspectors found the actions identified by the provider following the last inspection had not been fully implemented as outlined within their action plan response. However, inspectors acknowledged the proposed timescale had not passed.

Inspectors identified links to the wider community was very limited in accordance with residents wishes. Inspectors viewed a sample of residents' meetings, no evidence of community links were discussed despite this being identified as an action by the provider following the previous inspection. Therefore, inspectors found the action from the previous inspection remained in place during this inspection.

**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:**

Inspectors found the action identified by the provider following the last inspection had not been implemented. The contracts in place did not outline the services to be provided and all of the fees to be charged.

Inspectors were presented with a two and half page document outlining what was included and excluded in the fees. This had been developed since the last inspection



and was inserted into each resident's files. No evidence was available that residents or family members agreed to these charges. The original documents also remained in place within the ten samples of contracts viewed, all of which were dated 2015.

Inspectors identified that transport for social activities was not included within the fees paid by residents, as this was specified as an additional fee. Inspectors found this was also contained within the agreement for residents who had purchased their own vehicle. Therefore, agreements were generic and were not individualised. The organisation had their own transport department, however, no information was available in relation to how much residents would be charged for this service. On viewing residents' financial ledgers it was unclear how much transport was costing residents.

Inspectors found examples of inconsistent information between resident's contracts and financial assessments. One file viewed identified the resident was in receipt of a service seven days a week at a cost of €480, this was signed and dated in 2015. Inspectors identified this was inaccurate as the resident was not in receipt of a service seven days a week. A separate document identified as the financial assessment outlined the resident paid €521.80. Inspectors observed staff members had inserted a date of revision for June 2016 and August 2018, yet, it was unclear what was reviewed. The information within the document was the information which was devised in 2015.

**Judgment:**

Non Compliant - Moderate

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

Inspectors found the four actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response. Inspectors acknowledged the timeframe for these were late January and February 2018. Therefore, improvements continued to be required in relation to residents' personal social plans to ensure the wishes and preferences in accordance to their social needs were accurately

reflected.

Inspectors requested to view a sample of residents' social plans in one house. Inspectors were informed these had yet to be completed. Within another house inspectors requested to view one resident's plan. The plan contained within the resident's file was not up-to-date. Later in the day inspectors were presented with an updated document. Inspectors were informed this was locked away in a filing cabinet. Inspectors found the management of the resident's social plan required improvement to ensure staff providing care to the resident had access to this document.

Between the other two houses a sample of four residents' plans were viewed. The system had changed since the last inspection, to an assessment leading to one of the following plans being devised which included a reflex plan, sensory plan or exploratory plan. Some staff spoken with were not familiar with the outcome in relation to how a resident ended up with one type of plan if they received the same scoring following assessment. Staff identified that a staff member outside the designated centre assisted in completing this document therefore they were not familiar with the process. Inspectors were informed once the plan was devised goals were set in the following categories "goals I should have and goals I want". Inspectors asked how these goals were identified, however, this information was not available from staff on the day of inspection working in the designated centre. Nor was it clear that individual residents were involved in the development of these goals. Inspectors also identified that goals were generic across some plans viewed for example, to support the resident in the running of the house. From the assessment completed no evidence was available that this was an area which the resident wished or wanted to participate in. It was also evident that the goal was not attributed to the type of plan required for the resident following the assessment. For example, a resident with a reflex plan and another resident with a sensory plan contained the very same goal. From viewing the guidance document available to staff this was not consistent as the task of running the house should have been broken down and presented one step at a time. Another plan viewed identified the same goal yet, the assessment identified the resident was unable to do activities but responds to close contact of others.

Inspectors viewed documents which recorded the social activities residents were involved in within the designated centre. The record was viewed for 14 days for one resident three of the days contained no record. The record highlighted that on eight evenings the resident walked around the inside of their home. Within another resident's records, sitting in chair was recorded as an activity. Significant improvements were still required this aspect of care provision. While the provider had outlined plans in place these had, yet, to bring about a positive outcome or impact on the quality of lives for residents from a social perspective.

**Judgment:**

Non Compliant - Major

**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:**

Inspectors found the two actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response.

The centre had a policy on the management of risk. The centre maintained a risk register, this had been developed since the previous inspection which outlined risks in the centre and the controls in place to manage the risks. Risks included medication, falls, fire, transport and hot water. There were individual risk assessments for residents in place, these included epilepsy, falls and choking. Inspectors found improvements were still required in relation to individual risk assessments and the location risk assessments as these did not fully reflect practices in place. For example, a control measure was identified as a low arousal environment, however, the environment on the day of inspection was very noisy with one resident vocalising very loudly.

Inspectors viewed residents' risk assessments and found inconsistent information in relation to residents' preferences such as, likes a quite environment and when speaking with staff they identified that resident does not mind the environment which is usually very noisy. One inspector observed a resident engaging in self injurious behaviours when the environment was noisy. The inspector was informed this was not related to the noise at the time. Within another risk assessment a resident was identified as requiring two familiar staff to accompany them on visits to the community. Inspectors found this was not always the practice which staff confirmed on the day of inspection. Overall inspectors found the assessments in place were not reflective of practice.

Within the location risk assessments viewed improvements were required in relation to fire and the guidance available to staff. The process within the centre in the event of a fire during the night required staff members to leave residents alone in houses if they determined that it was safe to do so. However, this was not risk assessed within the location risk register. Inspectors were informed that the management of the centre were currently reviewing this process. Inspectors also identified improvements in relation to the guidance available to staff members for example, one file identified a specific process to be followed should a fire take place within the house. One inspector went to the locations identified within the residents PEEP's (personal emergency evacuation plans) to identify if the measures were in place. However, the inspector found the identified items were not in the specified locations. This was further compounded by the fact that the house was staffed by an agency staff member who had not worked in the house on the previous two nights. Inspectors brought this to the attention of the provider on the second day of inspection. The PEEP's guide staff in relation to the level of assistance residents require to safely evacuate.

Fire containment measures required improvement within the centre as inspector observed a fire door in one of the kitchens wedged open with a chair. This had also been identified in a previous internal audit, however, the practice had not changed nor had any measure been implemented to assist staff rectify this issue.

Certificates and documents were present to show the fire alarm, fire equipment and emergency lighting were serviced by an external company in 2017. Inspectors also viewed weekly checks completed by staff the guidance document available to staff members identified bells were checked on a weekly. However, staff confirmed this was not occurring, therefore, this required improvement to ensure the process documented was the actual practice within the centre. Inspectors viewed records of fire drills which demonstrated all residents evacuated the designated centre. The follow up to one identified that one house required a bleep, it was unclear if this had been sourced. The person in charge was requested to identify if this measure was put in place. It was confirmed a revised system in the form of radio controls were implemented. Inspectors identified the actions taken following the fire drill was not clearly documented in relation to the follow up.

The centre had infection prevention, and control procedures in place. Inspectors observed excessive usage of personal protective equipment in the form of disposable gloves usage and lack of hand hygiene in-between usage. Inspectors also identified one sharps box was in use which had no tagging system or label for identification purposes this was also identified during the previous inspection.

There was a system in place within the centre to record accidents and incidents to ensure preventative measures could be implemented in order to mitigate reoccurrences. However, on the day of inspection, some of these incidents were awaiting review from management since the 03 of January. Inspectors identified this system required review to ensure if any measures required to be implemented were put in place as soon as possible to avoid repeat of the incident.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

Inspectors found the five of the seven actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response. Inspectors acknowledged that the completion date had not yet occurred for two of the actions. Behaviour support management and restrictive practice still required improvements.

Inspectors identified enhancements in relation to the content of intimate plans which had occurred since the previous inspection.

The review in relation to residents' finances remained on going at the time of this inspection, however, items identified during the previous inspection had been refunded to the relevant residents. Inspectors also found that resident's finances were checked in relation to balances, however, no checks or safeguards were present to ensure items logged within resident's ledgers were actually purchased. Inspectors were shown a template for an audit to commence in relation to cash and ledger check this was yet to be commenced.

Guidance for staff in relation to behaviours that challenge required improvement as plans viewed were not effectively guiding practice and some inconsistent information was contained within these documents. The documents did not identify the cause of the behaviour and what measures should be taken to alleviate the cause of the behaviour. This was also identified at the previous inspection. In addition one plan viewed identified the resident sat with peers at meal times, however, on the day of inspection this resident was assisted to sit at a separate table with a staff member. When inspectors asked why this was the practice staff identified it was the resident's choice and also due to the potential of behaviours to be displayed.

Restrictive procedures including chemical and environmental restraint were used however, some of these were not used in accordance with evidence based-practice. One resident was prescribed a PRN (a medicine only taken as the need arises) medicine to alter their behaviour. The guidance available to staff members did not clearly identify the conditions when this was to be administered. Some environmental restrictions in place also required improvement to ensure impact of these were considered in relation to the other residents living in the house. Other restrictions were also identified, however, the evidence based rationale for use was unclear in relation to the purpose of the restrictions and recording of their usage. However, inspectors identified improvements in place in relation to the management of the locking of the external doors in one house which had occurred since the previous inspection. There was a clear recoding system in place and this restriction was awaiting review by the rights committee.

Inspectors viewed safeguarding plans in place and a number of these were within the one house, due to the compatibility of residents. Some of these plans viewed did not contain sufficient detail to guide staff members effectively in relation to the specific risk.

Inspectors spoke with members of staff who were clear in relation to what was the procedure should an allegation of abuse arise within the designated centre and the different forms of abuse this was an improvement from the previous inspection.

From viewing a sample of 34 members of staff training records, four staff members required training in behaviour including de-escalation and intervention techniques and three staff members required refresher training.

**Judgment:**

Non Compliant - Moderate

**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:**

During the course of this inspection, inspectors became aware of an incident which was not notified to the Chief Inspector as required by regulations.

Inspectors identified a resident sustained an injury which required immediate hospital treatment. This was not notified within three working days to the Chief Inspector.

**Judgment:**

Substantially 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

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

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

**Findings:**

Inspectors found the action identified by the provider following the last inspection had not been fully addressed. Residents had very limited opportunities for new experiences and social participation.

Inspectors viewed a sample of residents' files to ascertain how the action identified by the provider was implemented. However, evidence of opportunities for new experiences, social opportunities, education and training was not evident. Inspectors did acknowledge some plan viewed included a skills development component, however, these skills were not identified in a step by step process for residents to achieve and for staff members to consistently use the same approach with residents to achieve the specific skill they wanted to achieve.

**Judgment:**

Substantially Compliant

**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**

Health and Development

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

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

**Findings:**

Inspectors found the two actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response. Improvements were required to ensure residents assessed healthcare needs were met.

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. Inspectors viewed a sample of 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:

- no information in relation to the management of a condition despite the resident being prescribed a PRN medication of this condition. Instead the condition was briefly discussed, this did not guide staff members effectively
- the recording of the implementation of healthcare plans was not evident in relation to insulin management

- within another plan viewed it was specified that un-thickened fluids could be given to resident, however, the un-thickened fluids were only to be given by staff trained in dysphagia management, staff confirmed on the day of inspection this had not occurred nor was this evident within the training records viewed.

Inspectors acknowledged improvements since the previous inspection in relation to the provision of food to residents and areas identified in relation to lack of choice and a person centred approach to mealtimes was not observed during this inspection. Inspectors identified that the feeding eating drinking swallowing (FEDS) guidelines in place were implemented as required.

Inspectors also identified a number of plans had been reviewed since the previous inspection. These were providing clear guidance in relation the healthcare needs of residents for example, diabetes mellitus.

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

**Judgment:**

Non Compliant - Moderate

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

Inspectors found one of the two actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response. Suitable practices in relation to the administration of medication and the system in place for some PRN (a medicine only taken as the need arises) medicine continued to require improvements.

Inspectors viewed medications administration record sheets and found one medication was not administered as prescribed. This was highlighted to staff members on the day of inspection.

Inspectors 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. This was also identified on the previous inspection.

Medication was supplied to the designated centre from the organisations based pharmacy, medication was recorded when received. However, there was no stock control within the centre to identify the quantity of medication held within each house at specific intervals.

There was a system in place for recording, reporting errors and reviewing medication. Inspectors viewed one incident which occurred within the designated centre, the previous night involving a unfamiliar staff member. No ill effects were observed to have been experienced by the affected resident.

Inspectors found there was no system in place to encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences as no risk or capacity assessment had taken place for residents.

Inspectors did acknowledge the improvements in relation to the storage of medicines and keys for the medication press were kept in the possession of staff members during the course of the inspection. One inspector observed a medication round and identified improvements in the practice observed.

**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:**

Inspectors found the action identified by the provider following the last inspection had not been implemented as outlined within the action plan response. Improvements continued to remain within the details contained in the statement of purpose.

Inspectors found 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. For example, the total staffing complement, in full-time equivalents, for the designated centre with the management and staffing complements as required in Regulations 14 and 15.

Inspectors also identified the copy of the statement of purpose available within one of the houses was dated February 2016, this was not the most current copy of the document available to staff members, residents and their representatives.

**Judgment:**

Substantially Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Inspectors found two of the four actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response. While progress had occurred improvements remained in the area of oversight to ensure safe, consistent and effective delivery of care in accordance with residents needs. This was evident through the levels of non-compliance identified during this inspection.

The person in charge was supernumerary to the rota and was supported by two clinical nurse one managers who was also supernumerary. Since the previous inspection the person in charge had changed. The provider had appointed a clinical nurse manager three to the position, while a clinical nurse manager two was being recruited.

Inspectors requested to view minutes of staff meetings within the designated centre, within one house these could not be located. Within another house inspectors viewed eight minutes of meetings, however, the person in charge was only present for two of these and another two meetings had a clinical nurse manager one present. It was found that this was not providing staff members with sufficient guidance or oversight as residents were the only topic discussed within the majority of meetings. Inspectors also identified there was a lack of follow up to areas identified within minutes. For example, a meeting in relation to one resident's transport contained no follow up nor was there

evidence of the meeting within the resident's file or the agreed risk assessments completed.

Inspectors found the monitoring of the service provided was not effective as limited audits were conducted. Audits in relation to the administration of medication were not complete. Inspectors did view some audits conducted by a pharmacist. Inspectors viewed an audit of risk assessments, however, there was no evidence of follow up. Inspectors viewed other action plans which were undated with no follow up evident.

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. Inspectors viewed a sample of six staff members' performance appraisals. Only two of these staff members had plans completed for 2017. Inspectors 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 since the previous inspection on 08 and 18 December 2017.

**Judgment:**

Non Compliant - Moderate

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

Inspectors found four of the six actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response. While progress had occurred Improvements remained in the area of staff supervision, allocation of staff to meet the assessed needs of residents and continuity of care.

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. Inspectors acknowledged work had been completed to assess the support needs of residents and a

plan was in place to implement changes to rotas to reflect the assessments in place.

Inspectors found 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. Inspectors viewed the proposed and actual staff rota and identified relief staff were used on a daily bases within the centre. Within one of the houses an agency staff member was present on the previous two nights, this member of staff had never worked in the house before and was the only member of staff on duty in the house. However, inspectors acknowledged improvements had occurred in this area with the introduction of a core relief panel for this designated centre.

Staff rota's present in the designated centre represented the staff members present in the designated centre over a 24-hour period. The clinical nurse managers one's who were allocated to specific houses to provide supervision to staff members in the form of observation were also included in the rotas. Inspectors were informed that a supervision system had been devised and this would become operational for all staff members within the designated centre in quarter one of 2018. Inspectors found improvements remained in place to ensure the rota present reflected actual practice in relation to the numbers and identity of staff on duty. Inspectors were informed in one house a staff member would be commencing a shift at 15:00hrs. When one inspector asked where and who was this staff member as it was 15:45hrs the inspector was informed the rota may have changed and the staff would be on at 16:00hrs. Inspectors also viewed another rota in a second which was also not reflective of the staff members or numbers on the day of inspection.

From viewing 34 staff members' training records two staff members required refresher training in the area of fire safety and three staff members required refresher training in the area of people moving and handling.

**Judgment:**

Non Compliant - Moderate

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

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

**Findings:**

Inspectors found one of the three actions identified by the provider following the last inspection had not been implemented as outlined within the action response. Improvements remained in relation to the availability of schedule 4 documents.

Inspectors viewed schedule 5 folders within two of the houses and these contained the up-to-date policies available within the organisation.

Inspectors acknowledged some improvements in relation to the retrieval of some Schedule 3 documents since the previous inspection. There was also a reduction in the duplication of records as travelling folders containing residents information were no longer used, instead one file was in operation for residents.

Inspectors found some schedule 4 documents were not available within the designated centre on the day of inspection in relation to the record of testing of fire equipment including the fire alarms. This was also identified on the previous inspection. Staff members had to source these on the day of inspection.

**Judgment:**

Substantially Compliant

**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 report<sup>1</sup>**

<b>Centre name:</b>	A designated centre for people with disabilities operated by Cheeverstown House Limited
<b>Centre ID:</b>	OSV-0004926
<b>Date of Inspection:</b>	18 & 19 January 2018
<b>Date of response:</b>	16 March 2018

**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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Each resident's privacy and dignity was not always respected in relation to their intimate and personal care.

**1. Action Required:**

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

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 will be reviewed to ensure that they guide staff practice

**Proposed Timescale:** 02/04/2018

**Theme:** Individualised Supports and Care

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

Some residents did not have access to or retain control of their personal property and possessions in relation to vehicles purchased.

**2. Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

1. There is 1 resident in the DC who owns a vehicle. Another resident's family donated a vehicle to Cheeverstown.
2. Vehicles log books to be put in place outlining the resident's bookings for these vehicles. Residents are given priority access at all times.
3. Contractual agreement will be outlined and agreed with resident (and family).
4. The vehicle will be identified as a capital asset in the resident's personal ledger.

**Proposed Timescale:** 30/04/2018

**Theme:** Individualised Supports and Care

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

Some residents did not retain control of their own clothes.

**3. Action Required:**

Under Regulation 12 (3) (a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

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

- All clothes are personal to each individual.
  - Each residents clothes are washed separately and not mixed with other residents.
- There is a procedure in place outlining this which is communicated with all staff.

**Proposed Timescale:** 02/04/2018

**Theme:** Individualised Supports and Care

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

A complaint remained opened and unresolved; the complaints log present within one house in the centre contained one complaint from June 2016

**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 complaint has been resolved and this is documented in the complaints log - completed

**Proposed Timescale:** 02/04/2018

### **Outcome 02: Communication**

**Theme:** Individualised Supports and Care

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

Staff members had not received any training in the area of communication through LÁMH despite signs used to communicate with some residents within the centre.

**5. Action Required:**

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

Staff training will be planned

**Proposed Timescale:** 02/04/2018

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

**Theme:** Individualised Supports and Care

**The Registered Provider (Stakeholder) 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:**

Residents will be supported towards their social goals achievement as identified in 'My Life Plan'. To achieve an identified goal, the resident will be supported to access their community services. Each plan is individual to the resident. Links to community being incorporated to 'My Life Plan'

Residents meeting format is under review.

**Proposed Timescale:** 30/06/2018

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

- Written agreements viewed were not up to date to reflect the provision of services including the support, care and welfare of the resident.
  
- 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:**

1. The Contracts of Care will outline the services to be provided to each Resident.
2. All residents and families will be communicated with in relation to the introduction of Appendix 1 (in progress)

**Proposed Timescale:** 30/06/2018

**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 health, personal and social care needs of each resident was not available within the designated 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:**

1. Review of each personal plan
2. MDT agreement the plan is current and reflects present social care needs of individual resident
3. MDT agreement the plan guides practice at MDT meeting co-ordinated by the managers
4. Staff support residents guided by written plan - practice observation by management of DC and senior management
5. 100% of personal plans will be reviewed annually or as required
6. 50% of staff will receive training in 'My Life Plan' in the first two quarters.

**Proposed Timescale:** 30/06/2018

**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 nor was there a system in place for this to occur.

**9. 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:**

At review, the effectiveness of the plan will be assessed. MDT discussion will inform plan reviews

**Proposed Timescale:** 30/06/2018

**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 for all residents within the centre.

**10. 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:**

All personal plans will be completed

**Proposed Timescale:** 30/06/2018

**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 is a change in needs or circumstances.

**11. 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 personal plans will be completed and reviewed annually or more frequently if required

**Proposed Timescale:** 30/06/2018

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

The systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies required improvement.

**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:**

Individual Risk Assessments will be reviewed with attention to control measures

identified.

Location Risk Assessments will be reviewed.

The review of night time fire/emergency evacuation is in process. If resident's are left alone in houses, there will be a risk assessment completed.

The new night-time fire evacuation procedure will then be rolled out to the staff groups through education and a schedule of drills

Personal Emergency Evacuation Plans will be updated in accordance

**Proposed Timescale:** 30/04/2018

**Theme:** Effective Services

**The Registered Provider (Stakeholder) 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:**

Staff will be directed to read and practice according to Cheeverstown Infection Prevention and Control Policy

Local information session in Infection Prevention and Control will be delivered at DC level (by 02/04/2018)

**Proposed Timescale:** 30/06/2018

**Theme:** Effective Services

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

The arrangements for containing fires required review.

**14. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

The review of night time fire/emergency evacuation is in process. If resident's are left alone in houses, there will be a risk assessment completed.

The new night-time fire evacuation procedure will then be rolled out to the staff groups through education and a schedule of drills  
Personal Emergency Evacuation Plans will be updated in accordance

The chair has been removed. Staff have been reminded on requirements to keep fire doors accessible (complete)

**Proposed Timescale:** 30/06/2018

### **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Some chemical and environmental restrictions used, were not applied in accordance with evidence based practice.

**15. 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:**

The 'prn' protocol for chemical restraint has been reviewed for residents. The rationale for its use is set out in the protocol to guide Staff and is reviewed per 6 monthly or as required.

The environmental restriction has been reviewed to ensure the least impact on the residents in the house.

**Proposed Timescale:** 02/04/2018

**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.

**16. 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:**

A. MDT review of Positive Care Support Plan and agreement that the plan guides staff practice. Staff will be involved and given information on the PCSP to guide their support of individuals

There will be a schedule of review of Positive Care Support Plans for those residents who require same, with MDT input. 6 residents have been identified as priority from DC3

B. C. If a restriction is required and evidence based, the documentation and reasoning behind the restriction in use will be clearly evident in the individuals care plan.

**Proposed Timescale:** 30/06/2018

**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 34 members of staff training records, four staff members required training in behaviour including de-escalation and intervention techniques and three staff members required refresher training.

**17. 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:**

There is a schedule of MAPA training for staff within the centre

**Proposed Timescale:** 30/06/2018

**Theme:** Safe Services

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

Some 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 as resident's plan were not guiding practice.

**18. 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:**

MDT review of Positive Care Support Plan and agreement that the plan guides staff practice

There will be a schedule of review of Positive Care Support Plans for those residents who require same, with MDT input. 6 residents have been identified as priority from DC3

**Proposed Timescale:** 30/06/2018

**Theme:** Safe Services

**The Registered Provider (Stakeholder) 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 and peer to peer abuse.

**19. 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:**

1. Staff must follow the Cheeverstown Adult Safeguarding policy
2. There is a schedule for staff within the DC to attend Safeguarding Training
3. Staff will demonstrate an awareness of Safeguarding Policy and Procedure, inclusive of financial abuse
4. 100% of staff will read Cheeverstown Policy on Personal Money and Possessions
5. There will be local delivery of Safeguarding education and application to daily practice within the DC as part of the approach to address the staff knowledge deficit.
6. A Finance audit on Service User Monies has commenced and there will be follow up on actions identified from this

The particulars to the safeguarding plans in the house referred to in the action plan will be discussed at a Clinical Governance DC3 meeting, and actions will and identified

**Proposed Timescale:** 30/06/2018

**Outcome 09: Notification of Incidents**

**Theme:** Safe Services

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

The Chief Inspector was not notified within 3 working days of the occurrence in the designated centre of any serious injury to a resident which required immediate hospital

treatment.

**20. Action Required:**

Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

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

The PIC is aware of her regulatory responsibilities and all notifications will be made in a timely manner.

**Proposed Timescale:** 02/04/2018

**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 access to education and training in relation to social activities were 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:**

An MDT group will focus on Skills Development/ Task Analysis for identified individuals. An education plan will be put in place for staff on how to support individuals with regard to this.

**Proposed Timescale:** 30/06/2018

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Some medical treatment recommended for residents was not facilitated, nor had staff members received training in the required area.

**22. 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:**



Records of those trained will be available within the Centre.

Regular staff working in the house where a resident requires assistance for unthickened fluids will receive specific training – a plan for this training will be agreed with SLT

**Proposed Timescale:** 02/04/2018

**Theme:** Health and Development

**The Registered Provider (Stakeholder) 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 of the samples viewed.

**23. 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:**

The healthcare plan in relation to insulin will be reviewed and implemented.

The prn medication prescribed for an individual will be linked to a relevant care plan.

**Proposed Timescale:** 02/04/2018

## **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:**

One medication was not administered as prescribed.

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

There was no stock control within the centre to identify the quantity of medication held within each house at specific intervals.

**24. 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:**

The PRN medicine now gives clear guidance for the maximum dose in a 24 hour period

Stock levels in houses under review with the pharmacist to ensure adequate supply (avoiding over-stocking)  
Stock levels are referred to in the new Medication Audit

**Proposed Timescale:** 30/06/2018

**Theme:** Health and Development

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

There was no system in place to encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences as no risk or capacity assessment had taken place for residents.

**25. Action Required:**

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

Self -Administration Assessment and Procedure will be incorporated into the Review of the Medication Management Policy in 2018

**Proposed Timescale:** 31/12/2018

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The current version of the statement of purpose was not available to residents and their representatives within one of the houses.

**26. Action Required:**

Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

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

The most up-to date Statement of Purpose is available in each house.

**Proposed Timescale:** 02/04/2018

**Theme:** Leadership, Governance and Management

**The Registered Provider (Stakeholder) 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 this designated centre.

**27. 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 will be reviewed in relation to staffing levels following roster changes in response to assessed needs

**Proposed Timescale:** 30/06/2018

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

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 was not taking place.

**28. 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:**

- CNM1s are on rosters to houses
- CNM1s will spend 75% of their working day in houses guiding practice and supervising staff.
- Daily supervision sheet – this will be completed by CNM1 (or delegated lead) 3 days weekly and subsequent follow up on improvement areas identified within house
- In the absence of the CNM1 on shift, a senior staff will be identified as shift lead to a house. This staff will have a clear role within the house as 'in charge' of shift.

**Proposed Timescale:** 02/04/2018

**Theme:** Leadership, Governance and Management

**The Registered Provider (Stakeholder) 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.

**29. 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:**

There will be a schedule of DC meetings chaired by the PIC with CNMs and staff within the DC. If the PIC is absent, it is chaired by the CNM 1. These will take place monthly and will be documented. The actions will be followed through.

The audit cycle has been agreed with the PIC. The audits, the schedule and the action plans (inclusive of timeline and person accountable) will all be visible to the Head of Campus. Priority focus for remit of Urgent Action Plan

1. Social / My Life Plan
2. Medication
3. Financial Audits

**Proposed Timescale:** 02/04/2018

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider (Stakeholder) 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 designated centre.

**30. Action Required:**

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

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

The PIC is working with the Head of Cheeverstown Centre to address vacancies. There have been 2 nurses allocated to DC3 since this inspection.

**Proposed Timescale:** 30/06/2018

**Theme:** Responsive Workforce

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

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

**31. 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:**

The roster is currently being adapted following completion of the assessment of needs.

**Proposed Timescale:** 30/06/2018

**Theme:** Responsive Workforce

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

The actual staff rota viewed within two houses was not reflective of the actual staff members present in the designated centre.

**32. 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 available in the house will be current. If there are changes due to unforeseen absence or late confirmation of Support Team or Agency availability, the staff in the house should update the roster with the most recent information (as provided to them by the manager). Staff will be reminded of their duty to do this.

**Proposed Timescale:** 02/04/2018

**Theme:** Responsive Workforce

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

From viewing 34 staff members' training records two staff members required refresher training in the area of fire safety and three staff members required refresher training in the area of people moving and handling.

**33. 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:**

There will be a schedule of staff training

**Proposed Timescale:** 02/04/2018

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider (Stakeholder) 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 record of testing of fire equipment including the fire alarms.

**34. 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:**

Schedule 4 documents will be available within the centre

**Proposed Timescale:** 02/04/2018