

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Centre 4 - Cheeverstown House Residential Services (Senior Citizens)
Centre ID:	OSV-0004927
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Limited
Lead inspector:	Karina O'Sullivan
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	17
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

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

The inspection took place over the following dates and times

From:	To:
14 December 2017 09:00	14 December 2017 18:30
15 December 2017 10:00	15 December 2017 16:30

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 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 July and August 2017. Due to the significant breaches found with the regulations from that inspection HIQA issued the provider and the chairperson of the board with a warning letter outlining the concerns from a regulatory perspective with a timeline of three months for the designated centre to be brought into compliance. The provider responded with a time bound action plan to address the significant failings identified in the centre.

The purpose of this inspection was to inform a registration decision and to confirm that actions outlined by the provider within the timeframes specified were achieved. However, the finding identified that out of the 36 breaches identified in August 2017, 24 of these were also found in December 2017, therefore, 67% of the breaches were repeatedly found. Inspectors did acknowledge improvements were occurring however, these were at the early stage of implementation and would require 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. Two inspectors were present for the first day of inspection with one inspector present on the second day. Inspectors met all residents and spoke with three residents and six 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 within 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, the four outcomes previously evidenced as major non-compliant had reduced to moderate non-compliant as systems were now in place, however, these were not fully operational or effective in relation to enhancing the quality of lives of residents.

This inspection report identified 30 actions in need of addressing, 14 outcomes were inspected, resulting in two outcomes, outcome 8 Safeguarding and Safety and Medication Management, being evidenced as major non-compliant. This area

required significant improvement to ensure that effective systems were implemented in the area of safeguarding to protect residents from all forms of abuse. Out of the remaining 12 outcomes inspected against, eight outcomes were found to be in moderate non-compliance, two outcomes were substantially compliant and two outcomes 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:

Inspectors found two of the three actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response. Consultation with residents continued to require improvement.

Inspector viewed the complaints log and identified improvements had occurred as measures identified for improvement in response to complaints were identified along with specific timeframes.

Inspectors acknowledged improvements in relation to respecting the privacy and dignity of residents, for example, door bells were observed in use when staff members were entering into the homes of residents. The practice of entering some residents bedrooms during the night to complete regular checks were documented in a number of residents files. However, some residents did not have any rationale in place for this practice when inspectors requested to view evidence for the checks in place.

Inspectors also identified some practices remained in place which did not demonstrate consultation with residents. Inspectors identified a practice during the weekend in relation to administering medication which required a resident to be in an upright position one hour before eating. Inspectors viewed the medication recording chart and this medication was administered one weekend a month at 08:00hours. However, the resident identified they would like to have a rest at the weekend and not wake up early. This was also documented in the resident's plan. Inspectors found this practice did not demonstrate the wishes of the resident were respected nor was the resident's personal

plan adhered to.

Inspectors viewed five residents' financial ledgers within the centre and found previous items were refunded to residents, however, during the course of the inspection, inspectors became aware that three residents had purchased their own vehicle. Inspectors requested to view the arrangements in place in relation to this, however, these were not available within the designated centre. On the second day of inspection two documents were presented to the inspector, however, these did not demonstrate that residents had access to and retained control of their personal property in terms of their vehicles purchased. One resident had paid €42,894.50 in 2008. There was no written agreement in place in relation to the use of this vehicle or what costs were incurred by the organisation or the resident. Two other residents purchased another vehicle between them and an email was provided to the inspector dated 2014, this congratulated the residents on their achievement of successfully purchasing this vehicle. 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.

No other aspect of this outcome was inspected during this inspection.

Judgment:

Non Compliant - Moderate

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 by the provider following the last inspection had been implemented. Communication aids and appliances used within the centre such as, visual rotas reflected the staff on duty in the centre during the inspection.

No other aspect of this outcome was inspected during this inspection.

Judgment:

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):

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

Findings:

Inspectors found that all actions identified by the provider following the last inspection had not been fully implemented as outlined within their action plan response. However, improvements had occurred in relation to residents accessing the community for social outings.

One resident informed an inspector of their recent day trip to another country to visit their sibling, this had involved a lot of planning with staff, the resident and also their family. This was a memorable experience for the resident involved.

The provider had identified as a response to the previous inspection that fortnightly meetings would take place, between residents' day centre and residential managers. The purpose of which was to explore further community engagement opportunities and how to meet resident's wishes. However, these were not evident within the centre on the day of inspection. Inspectors did acknowledge that some monthly meetings had occurred, however, evidence of exploring community engagements remained limited.

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 as 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 and the original documents also remained in place within the ten samples 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 this was costing residents.

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:

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 three actions identified by the provider following the last inspection had not been fully implemented in relation to social care needs. 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 acknowledged the improvements evident in relation to the provision of social activities for residents at weekends and evening times. Both staff members and residents identified the positive impact this was having for residents. Residents had attended music events and various trips to community amenities had occurred and others were planned.

Inspectors viewed a sample of eight residents' plans, one resident did not have a social plan in place, all other viewed had an assessment completed. This was followed up with a planning meeting conducted in collaboration with the residential staff. This included the resident and family members in accordance with resident's preferences. Inspectors were informed of the process which was implemented throughout the centre. This involved an assessment followed by a planning meeting which led to the development of a "my life plan or a my person centred plan". However, inspectors found some residents had both plans in place, yet, with different goals identified. Inspectors requested to view evidence of where these goals originated from, however, this was not available within the centre. Inspectors also identified some goals specified within resident's planning meetings were not followed through within resident's plans and there was no rationale why some goals identified within the planning meeting were contained in the resident's plan and others were not.

Inspectors identified some social goals were not social goals but instead related to medical conditions. Inspectors viewed evidence of progression in relation to some goals set such as, photography and knitting, other goals set had no evidence of progression such as, swimming. Therefore, while inspectors identified significant improvements had occurred in the area of social care the system was not fully operational yet.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Inspectors found one of the four actions identified by the provider following the last inspection had not been fully implemented. Improvements remained in the areas of fire and risk management.

The centre had a policy on the management of risk. The centre maintained a risk register which outlined risks in the centre and the controls in place to manage the risks. Risks included medication, falls, fire and chemicals. 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 as these did not include current measures in place.

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 risked assessed within the location risk register. In addition some staff members spoken with were not fully aware of the procedure to be followed in the event of a fire.

From viewing 35 staff members' training records six staff members required refresher training in the area of fire safety.

A sample of residents' PEEP's (personal emergency evacuation plans) were viewed these had been updated to reflect the needs of residents and to assist staff to safely evacuate all residents.

The centre had infection prevention, and control procedures in place. Inspectors observed personal protective equipment and hand hygiene facilities were available in the centre. Inspectors acknowledged the improvements since the previous inspection in relation to the disposal of waste and clinical waste. However, inspectors identified the storage facilities in one house was not suitable for items such as, individualised shower chairs and commodes and did not promote effective infection control measures.

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 four actions identified by the provider following the last inspection had not been fully implemented. Improvements remained in the area of chemical and environmental restrictions and the management of allegations of abuse along with improvements in staff members' knowledge.

Inspectors viewed an incident form which recorded an allegation of abuse, however, the

person in charge was not aware of this incident nor was there appropriate follow up conducted as a result of this incident which occurred on the 28 October 2017. Inspectors brought this to that attention of the provider during the inspection.

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 residents ledgers were actually purchased. There was no system of scheduled or unannounced checks to ensure residents money was used for items they required for instance.

Inspectors found intimate care support plans were in place; however, some of these still did not guide practice and did not contain sufficient detail to guide staff members in relation to maintaining the dignity of each resident. This was also identified during the previous inspection.

Guidance for staff in relation to behaviours that challenge required improvement as plans viewed were not effectively guiding practice and staff members present were unable to identify to inspectors what approaches were used to de-escalate the situation. Inspectors also identified behaviours support plans were completed by nursing staff only with no input from other members of the multi disciplinary team being evident.

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. Staff members spoken with were unclear in relation to the administration of this medication and the guidance available to them did not clearly identify the process. Staff members spoken with provided inconsistent information in relation to what indicators would identify when the resident would require this intervention. Some environmental restrictions in place also required improvement to ensure there was an evidence based rationale for use was clear and all staff members were aware of why the restrictions were in place. This was also identified during the previous inspection.

Inspectors spoke with members of staff and some staff members were unclear in relation to what was the procedure should an allegation of abuse arise within the designated centre and the different forms of abuse.

From viewing 35 staff members' training records, six members required training in the area of safeguarding residents and the prevention, detection and response to abuse. Three staff members required training in the area of the management of behaviour that is challenging including de-escalation and intervention techniques and six staff members required refresher training in the area.

Judgment:

Non Compliant - Major

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):

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

Findings:

Inspectors found the actions identified by the provider following the last inspection had been implemented as weekly activity logs for each resident had been introduced.

Inspectors also viewed evidence of collaboration among residential staff and day service staff in relation to enhancing the opportunities for social activities.

From the sample of eight residents' plans viewed each resident had an assessment in place.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Inspectors found two 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 ensuring 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 five healthcare plans and found some of these required improvement to ensure medical treatments recommended for residents were implemented and healthcare needs were met.

The inspectors found some assessments in place were not followed up on. For example, a resident assessed as a high risk in relation to their body mass index on the 14 August 2017. The interventions specified following this assessment was for the resident to be referred to the dietician. Inspectors requested progress in relation to this, however, none was present. Inspectors found some assessment documents were not directing care to meet the assessed needs of residents. Therefore, staff members were also not guided effectively to ensure some residents received the required healthcare provisions.

Inspectors also found the management of healthcare conditions such as, gastrointestinal issues were not accurately outlined in residents' plans. Inspectors viewed guidance, however, staff members identified the information was no longer current as the treatment plan for the resident had changed. Inspectors viewed another plan where urgent attention was documented as required in relation to mobility, yet, no evidence of follow up was available within the resident's file. From observations the inspector identified an alternative intervention was in use to assist the resident with their mobility.

The review process required improvement to identify the effectiveness of the interventions to ensure these were having a positive impact on residents' healthcare needs. For example, one plan dated 28 September 2017 was required to be reviewed in four weeks, however, no evidence of review was available. Another plan viewed in relation to fluid restriction was dated 08 September 2017 which should have been reviewed the following week, yet, no review was available.

Inspectors viewed feeding, eating, drinking and swallowing (FEDS) assessments in place for some residents, inspectors found staff were not always guided accurately in relation to this. One resident had two different consistencies specified within their file for example, texture A in one document and texture B in another document. Consistency and clarity regarding this resident's need was pertinent as they had been identified with a risk of choking. Inspectors also viewed another resident was provided with the incorrect utensils for eating purposes, this was not in accordance with the resident's guidelines. Another plan dated 03 June 2015 identified interventions were to be implemented for a trial period on 03 June 2015, however, these continued to be implemented on the day of inspection. Therefore, overall inspectors found some residents were not provided with the appropriate assistance in relation to eating and drinking in some instances.

Inspectors viewed improvements within the end-of-life assessments as these were now completed for residents whom required them.

Residents had access to a 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 three 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 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 during the previous inspection five months previous. Inspectors identified no changes had occurred to this practice and as a result the resident continued to receive medication not in accordance with their prescription.

Inspectors found some guidance documents in relation to PRN (a medicine only taken as the need arises) medicine did not contain accurate information and was therefore, not guiding practice. The was also identified on the previous inspection.

Inspectors also identified some residents' medication administration charts did not contain the maximum dose of PRN medicine to be administered in a 24 hour period.

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 the disposal of out of date medication since the last inspection.

Judgment:

Non Compliant - Major

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Inspectors found the 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. Areas included:

- The number, age range and gender of the residents for whom it is intended that accommodation should be provided.
- The fire precautions and associated emergency procedures in the designated centre
- 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 March 2016 this was not the most current copy of the document available to staff members, residents and their representatives.

Judgment:

Non Compliant - Moderate

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. Improvements were still required in 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 amount of actions reissued.

Since the previous inspection a new person in charge had been recruited. From speaking with the person in charge at length over the course of the inspection it was evident they had an in-depth knowledge of the individual needs and support requirements of each resident. Each staff members spoken with was extremely complementary of the support provided to them from the person in charge. They all acknowledged how approachable and available this member of staff was when the need arose within the designated centre. For this centre the person in charge was supernumerary to the rota and was supported by two clinical nurse one managers who were also supernumerary. The person in charge was aware of their statutory obligations and responsibilities with regard to the role of person in charge, the management of the designated centre and the remit of the Health Act (2007) and Regulations. Throughout the course of the inspection, the inspector observed residents interacting with the person in charge and were very comfortable in their communication with this member of staff. The person in charge worked on a full time basis within this designated centre.

However, inspectors found the management structure in place did not always have clear lines of authority and accountability among the layers of management within the designated centre. For example, inspectors reviewed an allegation of abuse that was completed by a member of the multi disciplinary team and then processed through the risk department without ever being brought to the attention of the person in charge of the centre.

Some improvements were evident throughout the inspection. The level of support required to operate this designated centre from other designated centres within the campus had reduced. For example, there was a reduction in the cross over of staff members to this centre from other centres. The person in charge and the provider identified that reliance on other centres to provide oversight and guidance to this centre would cease in 2018 when recourses are fully aligned. As changes to the rota and staffing levels would be implemented to ensure the designated centre could operate as a stand alone centre without relying on other centres for staff or management support.

Inspectors viewed minutes of staff meetings within the designated centre, these were previously house based. However, staff members worked between houses and since the previous inspection, team meetings had commenced between all houses within the centre. This was to assist with the provision of consistent care. Inspectors acknowledged this improvement, however, were unable to determine how effective this was in terms of residents care as this initiative had only recently commenced.

Inspectors continued to find the system of auditing practice very limited and not impacting on the quality of lives for residents. The quality of service delivered to residents in relation to health and social care remained unaudited from a centre's

perspective. Inspectors viewed medication 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. For example, when medication was not available there was no follow up identified or what action was taken to prevent the situation from re occurring, this was also evident for an incidence where medication was not administered. Inspectors had also identified this during the previous inspection.

Improvements had occurred within the arrangements to support, develop and performance manage all members of the workforce within the centre. The centre had a yearly performance appraisal system in place, inspectors viewed a sample of four staff members' performance appraisals.

The provider had carried out two unannounced visits on the 10 and 17 November 2017 within the designated centre since the previous inspection. The report from the visits was in draft format and an action plan was being devised. However, very similar findings were found in relation to the previous HIQA inspection where staff members were standing over residents while assisting them with eating and drinking. Inspectors identified this practice was not observed during this inspection.

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 five actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response. Improvements remained in the area of staff supervision, allocation of staff to met 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 rota's 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. However, inspectors acknowledged improvements had occurred in this area with the introduction of a core relief panel for the designated centre.

Rota's present in the designated centre now represented the staff members present in the designated centre over a 24-hour period.

From viewing 35 staff members' training records, refresher training was required by four staff in the area of people moving and handling.

Inspectors identified that supervision was taking place with all staff members, the person in charge identified a system had been devised and this would become operational for all staff members within the designated centre in 2018.

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 two actions identified by the provider following the last inspection had not been implemented as outlined within the action response. Improvements remained in the areas of Schedule 5 policies.

Inspectors found one of the Schedule 5 policies available within the designated centre was not reviewed at intervals not exceeding three years. The recruitment selection and Garda vetting of staff members policy was dated September 2014.

Inspectors also identified that the medication policy within one of the houses was not the current policy in place within the organisation.

Inspectors acknowledged some improvements in relation to the retrieval of some Schedule 3 documents since the previous 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:

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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-0004927
Date of Inspection:	14 & 15 December 2017
Date of response:	26 February 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:

Evidence that each resident participated in and consented, with supports where necessary, to decisions about their care and support were not available within the centre and some practices contradicted residents wishes.

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 (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:

Each resident participates in decisions relative to their care. The resident identified on the day of inspection with regard to medication timing has been followed up by the PIC with the GP. This continues to be under consultation with the resident.

Proposed Timescale: 20/03/2018

Theme: Individualised Supports and Care

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

The practice of staff entering some resident's rooms during the night to complete regular checks was not promoting the privacy and dignity of residents. The need for this practice was not evidenced based for some residents.

2. 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:

The need for this practice is now evidenced. All residents have a risk assessment in place pertaining to their preference to keep their bedroom door open.

Proposed Timescale: 20/03/2018

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 as outlined within the main body of this report in relation to vehicles purchased.

3. 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 are 3 residents in the DC who own vehicles. Vehicles log books to be put in

place outlining the resident's bookings for these vehicles. Residents are given priority access at all times.

2. Contractual agreement will be outlined and agreed with resident.
3. The vehicle will be identified as a capital asset in the resident's personal ledger.

Proposed Timescale: 20/03/2018

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 links with the wider community in accordance with residents' wishes were limited in terms of community integration.

4. 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:

Details on personal plans for residents are complete and accurate (complete 20/03/2018)

2. Each resident has identified goals, they will be supported by staff to develop a connection to their community and to fulfil their goals
3. Palliative Care plans will incorporate social outcomes (complete)
4. Residents are supported to achieve social goals in their community

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:

A. Some written agreements were not up-to-date to reflect the current fees and additional charges.

B. The agreement for the provision of services was unclear in relation to arrangements in place to provide transport to residents.

5. 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 and the fees will also be outlined.
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 Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Arrangements to meet the assessed needs of some residents were not in place.

6. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

1. 100 % completion of the assessment of need in the Centre (complete)
2. 100 % completion of the rosters to reflect the assessed needs (20/03/2018).
3. 100% completion of the Statement of Purpose the staffing compliment For the centre will be reflected in the Statement of Purpose.

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.

7. 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:

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

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 from a location and individual perspective required improvement.

8. 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:

1. The review of night time fire/emergency evacuation is in process. If residents are left alone in houses, there will be a risk assessment completed. The process should be finalised by the week ending 4th March 2018 (timescale 20/03/2018)

2. The new night-time fire evacuation procedure will then be rolled out to the staff groups through education and a schedule of drills week beginning 5th March 2018

3. Personal Emergency Evacuation Plans will be updated in accordance (timescale 31/03/2018).

4. Schedule 2 documents are available in all houses (complete)

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 storage of individualised equipment within one house required improvement to ensure the risk of healthcare associated infections were reduced.

9. Action Required:

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

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

The storage of equipment in the house identified at time of inspection will be brought to the Health & Safety Committee for discussion and a plan will be suggested by the PIC.

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

A. From viewing 35 staff members' training records six staff members required refresher training in the area of fire safety.

B. Some staff members spoken with were not aware of the arrangements for the evacuation of residents within the house they were working in.

10. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

1. There is a schedule of Fire Safety Training for the staff in the Designated Centre
2. Scheduled fire drills for the centre will take place.

Proposed Timescale: 30/06/2018

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:

Some staff 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 plans and guidance documents were not detailed enough to ensure consistent delivery.

11. 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:

1. There are 5 residents identified as priority for update of their Personal Care

Support Plans (PCSP) to include measures to take by staff in the management of behaviours and in de-escalation of challenging situations. A review schedule has been agreed with the PIC and Psychologist.

2. Staff support and education on the PCSP with regard to changes made will be provided by the PIC and management team

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:

Three staff members required training in the area of the management of behaviour that is challenging including de-escalation and intervention techniques and six staff members required refresher training in the area.

12. 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 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 as the rationale for use was unclear in some instances.

13. 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:

1. The 'prn' protocol for chemical restraint is agreed by the MDT
2. The rationale for its use is set out in the protocol to guide Staff and is reviewed per 6 monthly or as required.

Proposed Timescale: 20/03/2018

Theme: Safe Services

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

A. Residents were not protected from all forms of abuse as detailed in the main body of this report as appropriate action was not taken in relation to one incident.

B. Financial process also required improvement.

14. 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 with 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. This will include the procedure to follow if there is an allegation of abuse and the different forms of abuse

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 35 staff members' training records, six members required training in the area of safeguarding residents and the prevention, detection and response to abuse.

15. 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:

There will be a schedule of staff training in Cheeverstown Adult Safeguarding Policy & procedure. Staff will be compliant with this schedule.

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

16. 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:

1. Staff support residents according to their Intimate Care Plan.
2. Intimate Care Plans will guide Staff practice
3. Intimate Care plans will be current, and reviewed if required.

Proposed Timescale: 26/02/2018

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 that had been recommended for residents was not facilitated.

17. 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:

1. The 2 residents identified at the time of inspection as requiring follow up in relation to specific healthcare needs have been addressed (Complete).
2. 100% of residents will have timely access to healthcare services.
3. 100% of residents will have their healthcare requirements facilitated.

Proposed Timescale: 30/06/2018

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 provided as identified within the main body of this report.

18. 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:

1. The 2 residents identified at the time of inspection as requiring follow up in relation to specific healthcare needs have been prioritised (timeline 20/03/2018).
2. Each resident's healthcare needs plan to be reviewed and addressed as appropriate

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:

Assistance provided to residents with eating and drinking required improvements to ensure the assessed needs of residents were met.

19. 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:

1. 100% of Eating and Drinking guidelines for residents are current to the resident's needs
2. 100% of Eating and Drinking guidelines will be present in the houses to guide Staff practice
3. Staff will sit with residents or as per the FEDs guidelines when assisting them with their meals.

Proposed Timescale: 26/02/2018

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:

Appropriate and suitable practices were not in place in relation to the following:

- A. Administration for PRN medication as medication was not administered as prescribed
- B. Some guidance documents in relation to PRN medicine was out of date and medicine no longer prescribed for the resident as a PRN was specified in the guidance
- C. Some residents medication administration charts did not contain the maximum dose of PRN medicine to be administered in a 24-hour period.

20. 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:

1. Staff will be compliant with Cheeverstown Policy & Procedure for Medication Management
2. Medication will be administered only as prescribed. If an error is identified, this will followed up on appropriately
3. There will be an audit by the Managers of medication practice with the Centre quarterly.
4. The prescribed 'prn' medication and relevant guidance documents has been reviewed and changes made to ensure that information is accurate and guiding practice (for the resident identified at the time of inspection)

Proposed Timescale: 30/04/2018

Theme: Health and Development

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

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

21. 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:

System to be put in place to assess residents whose preference is to take their medication independently.

Proposed Timescale: 31/03/2018

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:

Some of 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 were not reflective of practice within the centre.

22. 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:

1. The Statement of Purpose will define the functions of the Centre in line with Schedule 1 of the Healthcare Act, 2007
2. 100% completion of rosters to reflect the assessed needs.
3. 100% completion of the Statement of Purpose, with the staffing compliment reflected on it.

Proposed Timescale: 30/06/2018

Theme: Leadership, Governance and Management

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

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

23. 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:

1. The copies of the Statement of Purpose in the houses are the most current.
2. The Statement of Purpose will be adjusted and the up to date version placed in houses

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 management systems were not evident within the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored as audits were limited and follow up or the development of action places was absent.

24. 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:

1. The roster in the houses are current and ensure residents can be informed of who is on duty.
2. Staff supervision and mentoring will be provided by the managers allocated to each house.
3. Named Managers assigned to each house will spend 75% of their shift present in the house. The purpose is to provide support and mentoring in relation to care practices in the house to ensure a continuity of care for residents.
4. The roster will be operational in all houses 20th March 2018

Proposed Timescale: 20/03/2018

Theme: Leadership, Governance and Management

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

Further improvements were required to ensure a clearly defined management structure was in place within the designated centre that identified the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

25. 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:

1. A clearly defined management structure is in place (complete).
2. Staff are aware of the reporting structure (complete).
3. The roster available to all houses will be current in 100% houses
4. The roster in all houses will reflect Staffing over 24/7 period.

Proposed Timescale: 20/03/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

At times residents were did not receive continuity of care and support due to the level of relief and agency staff members required to operate the centre.

26. 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:

1. Each house within the centre has a named team.
2. There are named core support team members to the houses.
3. Through the use of the Support Team, every effort will be made to fill unplanned vacancies with familiar staff (before sending to agency)

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 always organised in accordance with the assessed needs of residents.

27. 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:

1. The identification of Staffing allocations and skill mix based on the assessed needs of the residents.
2. 100% of the rosters to reflect the assessed needs
3. Rosters are being changed in line with the Support Needs Assessment

Proposed Timescale: 20/03/2018**Theme:** Responsive Workforce**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

From viewing 35 staff members' training records, refresher training was required by four staff in the area of people moving and handling.

28. 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 is a schedule within the Centre for staff training for moving and handling for 2018.

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:

Supervision of staff members was yet to be operationalized among all staff members within the designated centre.

29. 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:

There is a supervision of Staff schedule in place for the Managers to follow. This schedule has now commenced.

Proposed Timescale: 20/03/2018

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:

The current medication policy was not available to all staff within the designated centre, the document viewed by inspectors contained no date of implementation and was not the current document in use.

30. 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:

The Medication Management Policy is being updated and will be available to all Staff in the Centre.

Proposed Timescale: 20/03/2018

Theme: Use of Information

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

The recruitment selection and Garda vetting of staff members policy was dated September 2014.

31. Action Required:

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

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

The Recruitment selection Policy will Garda Vetting has been updated.

Proposed Timescale: 20/03/2018