

**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 CLG
Lead inspector:	Maureen Burns Rees
Support inspector(s):	Amy McGrath
Type of inspection	Unannounced
Number of residents on the date of inspection:	17
Number of vacancies on the date of inspection:	1

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
11 June 2018 09:30	11 June 2018 17:30
12 June 2018 09:30	12 June 2018 16:00

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

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

Summary of findings from this inspection

Background to the inspection:

This centre was placed on a six month regulatory plan by HIQA starting in February 2018. The regulatory plan was put in place as a result of significant non-compliances identified in a number of centres on the provider's campus. The provider was required to submit an urgent action plan and assurance plan in respect of each of the non compliances identified. This centre was one of three centres which had not had a registration decision made to date. It is proposed that a registration decision will be made at the end of the regulatory process for each of these centres. This centre was last inspected on the 14 of December 2017 and as part of this inspection the inspector followed up on actions from the last inspection.

How we gathered our evidence:

As part of the inspection, the inspectors met two clinical nurse managers, the head of care, the chief executive officer, four staff nurses, six care assistants and three agency staff. The person in charge was on leave at the time of the unannounced inspection but was interviewed by phone some days after the inspection on her return from leave. The centre comprised of four separate houses. Residents were

met with, in each of the houses. The inspectors met with 12 of the 17 residents living in the centre. A number of residents were unable to convey to the inspectors their views of the service but all of the residents were in good spirits and were observed to have warm interactions with the staff caring for them. The inspectors reviewed care practices and documentation such as care plans, medical records, accident logs, staff files, policies and procedures and daily records.

Description of the service:

The designated centre consisted of four houses which were located on a campus containing a number of residential and day services operated by the provider. Each of the houses provided full-time residential care for adults over the age of 18 years. The service provided was described in the provider's statement of purpose, dated February 2018. Each of the residents had their own bedrooms which had been personalised to their own taste. There was adequate communal space within each of the houses. The houses had a number of communal garden areas within the campus with a number of the houses also having an allocated garden area.

Overall judgment of our findings:

Overall, the inspectors found that there had been significant improvements since the last inspection and that the provider had put in place a number of additional systems to ensure that a good number of the regulations were being met or were in the process of being met. A governance plan and an urgent action plan had been put in place to address issues and non compliances identified. Senior management team walk arounds had been introduced to quality check those actions marked as complete on the urgent action plan.

The person in charge had been in the post since September 2017. She was interviewed over the telephone and demonstrated adequate knowledge of the regulations and of the care and support requirements for each of the residents. The inspectors were satisfied that she was a fit person to participate in the management of the centre. There remained some areas for improvement as listed below and within the body of the report.

Good practice was identified in areas such as:

- Residents rights, dignity and privacy were found to be upheld. (Outcome 1)
- There were arrangements in place to promote and protect the health and safety of residents and staff. (Outcome 7)
- Arrangements were in place to support residents on an individual basis to achieve and enjoy the best possible health. (Outcome 11)
- Arrangements in place to monitor the quality and safety of care and support in the centre had improved since the last inspection. (Outcome 14)

Areas for improvement were identified in areas such as:

- A written agreement outlining the services and fees provided, was not available on a number of the residents files reviewed. (Outcome 4)
- Improvements were required to ensure that the effectiveness of plans were reviewed and that residents family representatives and members of the multidisciplinary team were involved in the reviews of personal plans put in place.

(Outcome 5).

- Some improvements were required in relation to storage arrangements and the maintenance of a number of the individual houses. (Outcome 6)
- Appropriate behaviour support plans had not been put in place for a small number of residents identified to require same. (Outcome 8)
- It was observed on the day of inspection that medication in one resident's bedroom had not been appropriately stored and a medication prescribed for another resident had not been appropriately labelled. (Outcome 12)
- There had been significant changes to staffing arrangements in one of the houses on the week of inspection which impacted on the skill mix and consistency of care arrangements for residents in this house. There were a number of staff vacancies in the centre. Formal supervision arrangements for staff were in the early stages of implementation in the centre. (Workforce 17)

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):

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

Findings:

Residents rights, dignity and privacy were found to be upheld.

Residents were consulted with and participated in decisions about their care and support and the organisation of each of the houses. Each of the residents had their own bedroom and their privacy and dignity was observed to be respected by staff. At the time of the last inspection, a process for night checks was in place without a rationale for individual residents. Since that inspection, a review had been completed and a rationale for any night checks undertaken recorded based on individual residents needs.

There were appropriate arrangements in place for the management of complaints and complaints were found to have been responded to promptly.

At the time of the last inspection, some residents did not have access to or retain control of their personal property and possessions specifically in relation to vehicles purchased. Since that inspection, vehicles log books had been put in place outlining usage of vehicle with the identified resident who owns the vehicle getting priority usage. Contractual agreements had also been put in place and agreed with each resident. Residents vehicles were identified as a capital asset in the resident's personal ledger where appropriate.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

The centre had a policy on admissions which outlined the arrangements in place for admitting and transferring residents within the centre.

At the time of the last inspection, it was identified that some written agreements did not reflect the correct fees and additional charges, and did not clearly describe arrangements for the provision of transport for residents. On this inspection, the inspectors found that draft contracts had been revised to clearly list the services provided and fees payable. It was reported that all revised contracts had been sent out to residents family representatives for review and signing. However, at the time of inspection, a signed copy of the contract was not available on a number of the residents files reviewed.

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:

Resident's individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified. However, improvements were required to ensure that the effectiveness of plans were reviewed and that residents family representatives and members of the multidisciplinary team were involved in the reviews of personal plans put in place.

A full assessment of resident's needs was completed. A 'meaningfull activity' assessment had also been completed for individual residents. These assessments informed personal plans and a newly introduced 'my life plans'. Plans in place detailed the individual needs and choices of residents. There was evidence that there was some consultation with residents families regarding plans put in place. Personal goals and actions required to achieve same were recorded for individual residents. A new template to evaluate goals set had recently been introduced.

There was evidence that personal plans had been reviewed within the last year. However, some reviews undertaken did not assess the overall effectiveness of the plans and did not involve the residents family or representative. Multi-disciplinary team meetings for individual residents had been undertaken in March 2018 and the minutes from these minutes stated that revisions had been agreed to individual personal plans. However, there was no record made of what the revisions were or if they had been made.

The inspector reviewed records of 'my weekly plans' for individual residents which showed that they were engaged in a fair range of activities in the local community and inside the centre. Visual timetables had been put in place for residents regarding their daily planners. Good detail were recorded in 'my life plan' daily notes regarding activities residents had engaged in.

There was evidence that transitions for a number of the residents, to accommodation to better meet their assessed needs were planned. There was evidence of consultation with family representatives regarding these moves and the supports required.

Judgment:

Substantially Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

Findings:

The design and layout of the centre reflected the layout as described in the centre's statement of purpose. However, some improvements were required in relation to storage arrangements and the maintenance of a number of the individual houses.

The centre comprised of four separate houses located within a campus setting operated by the provider. Each of the residents had their own bedrooms which had been personalised to the individual tastes of the residents. There was adequate living space and an equipped kitchen within each of the houses. There was limited space for storage in a number of the houses with large pieces of equipment required by residents observed to be stored in bathrooms which meant that the use and cleaning of these areas was impacted.

Overall, each of the houses were decorated to a good standard and had a homely feel. All areas visited were observed to be clean and tidy. However, in some of the houses there was some chipped paint and woodwork, and the tiles on the floors in some of the bathrooms and toilets appeared worn.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

There were arrangements in place to promote and protect the health and safety of residents and staff.

Suitable precautions were in place against the risk of fire. At the time of the last inspection, it was identified that some staff required staff training and that arrangements for the evacuation of residents at night if needed, required improvements. On this inspection, staff had attended fire safety training and were clear on the arrangements for the evacuation of residents, in particular at night time. A fire risk assessment had been undertaken. Records showed that fire fighting equipment, fire alarms and emergency lighting were appropriately installed and serviced by an external company. Formal safety checks of fire equipment and other safety precautions were undertaken at regular intervals. A procedure for the safe evacuation of residents and staff, in the event of fire, was prominently displayed in each of the houses. Each of the

residents had a personal emergency evacuation plan in place which considered the mobility and cognitive understanding of the resident. Each of the houses had suitable night time staffing arrangements so as to ensure the safe evacuation of residents in the event of fire. The fire assembly point was identified with appropriate signage in an area to the front of each of the houses. Fire drills involving residents were undertaken at regular intervals with appropriate records maintained of those attending, time required for full evacuation and issues encountered.

There was a risk management policy in place, dated April 2015 which was in the process of being reviewed at the time of inspection. Since the last inspection, individual risk assessments for residents had been revised to clearly state current control measures in place. Site-specific risk assessments had been undertaken and appropriately recorded. A risk register was maintained as a 'living' document in each of the houses. There was a health and safety policy and procedure, which was specific to the centre. Health and safety checks were completed at regular intervals. There was an emergency plan in place to guide staff in responding to an emergency. The provider had a risk management department which was accessible as a resource for the centre.

There were arrangements for investigating and learning from serious incidents and adverse events involving residents. There were a relatively low number of incident reports across the centre. From a review of a sample of case notes, the inspector found that incidents had been appropriately reported with a record maintained of actions taken and further actions required. There was evidence that individual incidents were reviewed and discussed at staff team meetings. The providers risk management department had completed an analysis and trending report of the number and type of incidents across the centre and compared to centres across the service. This provided opportunities for shared learning across the service.

There were procedures in place for the prevention and control of infection. Colour coded cleaning equipment was in place and appropriately stored within each of the houses. Three of the houses had an allocated housekeeper whilst the fourth house had a contracted cleaner arrangement. The inspector observed that there were facilities for hand hygiene available. Overall areas were observed to be clean and tidy. Suitable cleaning schedules were in place.

Judgment:

Compliant

Outcome 08: Safeguarding and Safety

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

Theme:

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

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

Findings:

Overall, there were suitable measures in place to safeguard residents. However, appropriate behaviour support plans had not been put in place for a small number of residents identified to require same.

There was a policy and procedure on protection of vulnerable persons, dated March 2015, which was in line with the national guidance. The person in charge and staff interviewed were knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. There had been no suspicions or allegations of abuse since the last inspection. Risk assessments and safeguarding plans had been put in place where required. There was evidence that safeguarding arrangements were regularly discussed at staff handover with a 'safety pause' and at team meetings. The providers safeguarding officer had visited individual houses to brief staff. There was a policy on personal monies and possessions which was found to be adhered to.

Arrangements were in place to provide residents with emotional and behavioural support that promoted a positive approach to the management of behaviour that challenges. The centre had a policy on promoting positive approaches, dated March 2017. Overall, there was a low level of behaviour that challenges displayed in the centre. There was some guidance for staff provided within residents person centred plans, on how best to support residents. However, a detailed behaviour support plan was not available to guide staff in meeting the needs of a small number of residents identified to require such support. Deficits in relation to staff training and knowledge were identified at the time of the last inspection. On this inspection, training records showed that staff had received appropriate training in a recognised behaviour management approach and staff interviewed were familiar with safeguarding arrangements, the management of challenging behaviour and de-escalation techniques.

There was a policy and procedure on restrictive practices, dated October 2016. There was a restrictive practice log maintained and restrictive practices in place were regularly reviewed. Risk assessments had been completed for restrictive practices in place. Non compliances were identified at the time of the last inspection in relation to the use of chemical restraints in the centre. However, there were no chemical restraints in use at the time of this inspection.

The centre had an intimate care policy. Intimate care assessments and plans were in place for residents who required same. These were found to provide a good level of detail to guide staff in meeting the intimate care needs of these residents.

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):

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

Findings:

Arrangements were in place to support residents on an individual basis to achieve and enjoy the best possible health.

Residents' healthcare needs were met by the care provided. A number of the houses had a registered staff nurse on duty at all times whilst other houses had access to a staff nurse 24/7 within the campus. A general practitioner (GP) was based on the campus two days per week. Each of the residents had their own GP and access to an out-of-hours doctors service. Residents had access to a number of other therapeutic supports. These included: speech and language therapy, dietician, physiotherapy and clinical nurse specialists. Records were maintained of all contact with GPs and other health professionals. A register was maintained of required check ups and appointments with various health professionals.

At the time of the last inspection, the inspector had found that some medical treatments recommended for residents had not been facilitated and that appropriate healthcare for some residents had not been provided. On this inspection, and of the sample of files reviewed, it was found that a comprehensive health assessment and plans had been completed for residents. All recommended treatments had been provided. A log was maintained of health screening and checks required for individual residents with dates next due where applicable.

Residents dietary needs were being met. There was a food, nutrition and hydration policy, dated October 2016. The inspector observed that a healthy diet and lifestyle was promoted in the centre. There were arrangements in place for residents to be involved in choosing meals in individual houses. A weekly menu planner was agreed with residents and this showed that a varied and nutritious diet was provided for residents.

At the time of the last inspection, the inspector found that assistance provided to residents with eating and drinking required improvement to ensure the assessed needs of residents were met. On this inspection, the inspectors found that feeding, eating, drinking and swallowing (FEDS) assessments had been completed for residents identified to require same. Specific plans had been put in place to meet assessed needs and recommendations from dieticians were found to be implemented. Each of the houses had a fully equipped kitchen and a dining area, with adequate seating to allow meal times to be a social occasion. The inspectors observed staff supporting residents at

meal times in a kind and respectful manner with residents appearing to enjoy their meals.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Overall, the systems in place to support staff in protecting residents in relation to medication management were found to be satisfactory on this inspection. However, it was observed on the day of inspection that medication in one resident's bedroom had not been appropriately stored and a medication prescribed for another resident had not been appropriately labelled.

There was a policy and procedure on medication administration and administration, dated April 2015. A secure storage press was in place in each of the houses. Registered staff nurses were responsible for the administration of medications across the centre. Staff spoken with had a good knowledge of the requirements for the safe administration and management of medications. The inspector reviewed a sample of medication prescription and administration records and found that they had been appropriately completed and were regularly reviewed by the residents general practitioner (GP). Individual medication management plans were in place. Procedures were in place to check all medications ordered and delivered by pharmacy with medication stock control logs maintained. A pharmacist was available on the campus five days per week. An adequate supply of all medications was available in the centre.

At the time of the last inspection it was identified that a maximum dosage for PRN or as required medications was not always stated, some guidance in relation to PRN medications was out of date and that some PRN medications had not been administered as prescribed. On this inspection the inspector found that PRN medications had been appropriately prescribed and administered.

Further to the last inspection, systems had been put in place to assess residents ability and preferences in terms of self managing and administering their medications. Based on these assessments there were no residents responsible for the management of their own medications at the time of this inspection. Individual medication management plans were in place.

There were arrangements in place to review and monitor safe medication management practices in the centre. Medication audits were undertaken on a regular basis. There was evidence that the output from these audits, with any learning identified was discussed at staff team meetings.

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):

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

Findings:

Arrangements in place to monitor the quality and safety of care and support in the centre had improved since the last inspection.

There was a management structure in place. The person in charge reported to the head of care who in turn reported to the chief executive officer. Staff interviewed had a clear understanding of their role and responsibility, and of the reporting structure. There was a manager available 24/7 on the campus for support. Since the last inspection, changes had been made to the roster system with the introduction of an electronic roster to replace the printed rosters in each house, so that any changes made to the roster by a manager or the rostering team were immediately available within each house. Lead staff member on each shift were clearly indicated on the rosters reviewed on this inspection. There were weekly staff meetings held in each of the individual houses which were attended by staff from the specific house and the clinical nurse manager who oversaw the house. These informed centre meetings which were held and attended by the person in charge, clinical nurse managers and staff from each of the four houses.

The person in charge had taken up the post in September 2017. She had not worked within the service before this date but had more than 20 years management experience working with other service providers. She held a full-time position and was not responsible for any other centre. She was supported by one full time clinical nurse manager and two part-time clinical nurse managers. She was a registered nurse in intellectual disabilities and psychiatric nursing. She held a diploma in management. The

person in charge was on scheduled leave on the dates of inspection but was interviewed subsequently by phone. The inspectors found that she was knowledgeable about the requirements of the regulations and standards and had a good understanding of the individual care needs of each of the residents. The person in charge had recently commenced formal supervision with her line manager. It was noted that she had regular informal contact with her line manager. This provided assurances that she performed her duties to the best of her ability.

This centre is one of four centres operated by the provider which was placed on a six month regulatory plan by HIQA starting in February 2018. As a consequence the provider had put in place a governance plan and an urgent action plan to address non compliances identified in previous inspections. At the time of the last inspection, the management systems in place did not ensure that the service provided was safe, consistent and effectively monitored. Since that inspection, a range of audits had been undertaken in the centre as part of an audit cycle. These included audits of personal plans, medication management and residents finances. There was evidence that issues identified were reported to the senior management team with an action plan and timelines to address issues identified. A schedule of walk-arounds by members of the senior management team had been undertaken to quality check against those actions marked as complete on the urgent action plan and assurance statement to HIQA. An annual review of the quality and safety of care as required by the regulations had also been completed. Unannounced visits to the centre on a six monthly basis, as per the requirements of the regulations had been undertaken.

Judgment:
Compliant

Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

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

Findings:

There had been significant changes to staffing arrangements in one of the houses on the week of inspection which impacted on the skill mix and consistency of care arrangements for residents in this house. There were a number of staff vacancies in the centre but these were in the process of being recruited. Formal supervision

arrangements for staff were in the early stages of implementation in the centre.

There was a staff roster in place. Since the last inspection, an assessment of need had been completed for individual residents and the staff rosters had been changed to ensure more appropriate staffing in some areas. The roster had also been computerised which facilitated it being a 'living' document which was coordinated and maintained centrally. However, it was noted over the two days of inspection, that there were a number of changes made to the roster which were not reflected on the 'live' roster. The person in charge reported that the whole time equivalent staff complement for the centre was short by three staff members. There was evidence that recruitment was underway for these positions. At the time of the last inspection, residents did not always receive continuity of care due to the level of agency and relief staff members required to operate the centre. On this inspection, the inspector found that a panel of regular relief staff were used to cover staff vacancies which provided some consistency of care for the residents.

On the week of inspection, four staff were moved from one of the houses to a different designated centre in the community. Although this move was planned, contingency planning could have been improved so as to reduce the impact for residents.

The inspector noted that copies of the standards and regulations were available in the centre. Staff interviewed were knowledgeable about their role and of the regulatory requirements.

There was a training and development policy in place, dated July 2017. There was a training programme in place which was coordinated centrally by the provider. Staff training records reviewed by the inspector showed that all staff had attended mandatory training. Other training to meet specific needs of residents had been identified and sourced.

Overall effective recruitment and selection arrangements were in place. There was a recruitment and selection policy in place, dated January 2017. At the time of the last inspection, it was identified that some of the information as required by schedule 2 of the regulations were not in place. The provider reported that an audit of files was subsequently completed with deficits addressed. On this inspection the inspector found that the information as required by schedule 2 of the regulations was in place with the exception of a long term member of the staff team who did not have references on file.

Formal supervision arrangements were in the process of being developed for staff. This had been highlighted on previous inspections as meant that staff might not be appropriately supported so as to ensure that they performed their duties to the best of their abilities. It was reported that a supervision policy was in the process of being developed. The head of campus had commenced formal supervision with the person in charge but this had not yet been rolled out to other staff but this was planned.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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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 CLG
Centre ID:	OSV-0004927
Date of Inspection:	11 and 12 June 2018
Date of response:	27 July 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 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 signed copy of the contract was not available on a number of the residents files reviewed.

1. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each

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

resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

1. A newly revised copy of the Memorandum of Care will be sent to each family /NOK.
2. This will be followed up with a reminder phone call to return same if not received within two weeks. An update of this progression will be noted in resident's file

Proposed Timescale: 31/08/2018

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:

Multi-disciplinary team meetings for individual residents had been undertaken in March 2018 and the minutes from these minutes stated that revisions had been agreed to individual personal plans. However, there was no record made of what the revisions were or if they had been made.

2. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

1. A review of the form utilised to capture recommendations and minutes at multidisciplinary reviews is currently being undertaken.
2. This form will be used at the DC4 schedule of team reviews in October.

Proposed Timescale: 31/10/2018

Theme: Effective Services

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

Reviews undertaken did not always involve the residents family or representative.

3. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

1. Families will be invited to participate in the review of the resident's personal plan annually in accordance with resident's wishes.

2. This annual review will be carried out in conjunction with the MDT.
3. Residents, families (where appropriate) are invited to attend and fully participate in case conferences.

Proposed Timescale: 31/10/2018

Theme: Effective Services

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

Some reviews undertaken did not assess the overall effectiveness of the personal plans in place.

4. 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. There are 17 residents in DC4. The PIC will review the personal plans with the DC management team.
2. My Life Plan training includes giving staff guidance on how to review the effectiveness of a plan and all staff employed in DC4 will receive this training.
3. The evaluation form has been revised by the quality department to give clearer guidance to staff which will ensure that all relevant information and topics are covered within the review to measure the effectiveness of the plan.
4. Families will be invited to participate in the review of the resident's overall personal plan annually.

Proposed Timescale: 31/10/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

In some of the houses, there was some chipped paint and woodwork, and the tiles on the floors in some of the bathrooms and toilets appeared worn.

5. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

1. All of these repair work requests have been forwarded to the Facilities Manager.

Proposed Timescale: 31/10/2018

Theme: Effective Services

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

There was limited space for storage in a number of the houses with large pieces of equipment required by residents observed to be stored in bathrooms which meant that the use and cleaning of these areas was impacted.

6. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

1. The spare bedrooms have now been identified as the storage area for equipment and there is no plan to reuse these rooms as bedrooms.
2. Mobile hoists and shower chairs have been removed from bathroom and moved to new storage room.
3. There is a cleaning rota and schedule in place for bathroom and personal equipment.

Proposed Timescale: 30/09/2018

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:

A detailed behaviour support plan was not available to guide staff in meeting the needs of a small number of residents identified to require such support.

7. Action Required:

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

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

1. The behaviour support plan of the resident identified as requiring this support will be reviewed by the multidisciplinary team and changes made to ensure it guides staff clearly on the support the resident needs.
2. Staff training needs will be assessed and a plan of educational upskilling will be put in place in conjunction with the MDT

Proposed Timescale: 30/09/2018

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:

It was observed that medication in one resident's bedroom had not been appropriately stored and a medication prescribed for another resident had not been appropriately labelled.

8. 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. All medications in the Centre are now properly stored and individually labelled.
Complete

Proposed Timescale: 13/07/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

There had been significant changes to staffing arrangements in one of the houses on the week of inspection which impacted on the skill mix and consistency of care arrangements for residents in this house.

There were a number of staff vacancies in the centre.

9. 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 staffing and skill mix of the house has been revisited by the PIC and Head of Campus since the inspection. A 2nd familiar nurse has been assigned to the house. The remaining care staff to the house has now commenced in contract.
2. Recruitment efforts to fill remaining vacancies have been unsuccessful to date, but efforts are ongoing.
3. Vacant shifts are therefore filled by Support Team members familiar with the support needs of the residents in DC4. The use of unfamiliar agency staff is a last resource.

Proposed Timescale: 31/10/2018

Theme: Responsive Workforce

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

It was noted over the two days of inspection, that there were a number of changes made to the roster which were not reflected on the 'live' roster.

10. 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:

1. The findings within the report in relation to roster have been discussed with the managers in DC4 by the PIC. Any changes to named staff to houses are updated as a priority.
2. If a manager is in a house and cannot make a change to the roster, administration staff in the rostering department will do so on their behalf when called on by the manager. The live roster is up to date.

Proposed Timescale: 13/07/2018

Theme: Responsive Workforce

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

There had been significant changes to staffing arrangements in one of the houses on the week of inspection which impacted on the skill mix and consistency of care arrangements for residents in this house. There were a number of staff vacancies in the centre but these were in the process of being recruited. Formal supervision arrangements for staff were in the early stages of implementation in the centre.

11. 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:

1. All newly recruited Staff will receive full induction and training under the supervision of the CNM's and Senior Staff Nurses.
2. Staff will receive formal supervision by a DC manager quarterly. This meeting will compose of one Performance Development Planning meeting and 3 formal supervision meetings.
3. The PIC will schedule staff a date for this supervision. Staff will receive one to one

management supervision within the next 3 months

Proposed Timescale: 31/10/2018