Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004926
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Limited
Provider Nominee:	Brian Gallagher
Lead inspector:	Valerie McLoughlin
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	22
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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
21 April 2015 09:30	21 April 2015 18:30
22 April 2015 08:00	22 April 2015 19:30

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 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This registration monitoring inspection of Cheeverstown House Residential Services was announced and took place over two days. As part of the inspection, the inspector met with residents, relatives and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. The inspector received questionnaires from residents and relatives which were complimentary of the service being provided at the centre. The designated centre comprises four houses which form part of a larger campus. A support inspector focused on the outcome related to premises and the lead inspector visited the four houses where residents lived and monitored all the outcomes.

As part of the inspection, a fit person interview was carried out with the nominated person on behalf of the service. He was found to be knowledgeable in his role and the requirements of the regulations. Despite their being a management team with responsibility for the service, there was no nominated person as required by the regulations. The role of clinical nurse managers was to provide cover for all of the campus based services of which the designated centre was part. However the nurse manager was not available to adequately monitor the quality of care or supervise staff, which resulted in a fragmented approach to care for residents, and an inadequate standard of care for some residents.

The inspector found that residents were engaged in a range of activities during the day, and there were opportunities for them to take part in activities of their choice in the evenings and at weekends, but this could be limited due to the staffing levels.

The inspector found that residents were supported to develop and maintain personal relationships and links with their family and they were encouraged and welcomed to be involved in the lives of residents. There were appropriate arrangements in place to support residents' health care issues as they arose. Residents' communication needs were also assessed with communication needs were largely met to a good standard.

Assessment and personal planning required improvement. The assessment of need was not comprehensive and impacted on the quality of personal plans. The review of personal plans did not always identify if personal goals were achieved. Improved documentation was being rolled out to support the assessment and planning process which would address these deficits.
There were appropriate arrangements in place to support residents' health care issues as they arose, however follow through on referrals was not consistent.

It was identified as a concern that due to the size and layout of the multi occupancy bedrooms and bathrooms, dignity and privacy for all residents could not always be maintained.

An annual report of the quality and safety of care and support in the designated centre was not available. The Statement of Purpose did not fully meet the requirements of the regulations.

Other areas for improvement included the development and implementation of contract of care, implementation of the risk management policies to guide staff practices, staff training and supervision, improvement in the management of residents' finances, to make the complaints procedures accessible in the designated centre, procedures around the identification and management of restrictive practice, and general governance and management procedures in the centre.

Inspectors found that the provider had addressed four of the areas of non-compliance that had been identified on the previous inspection. These related to medication management. Two actions were partly addressed; however 16 actions had not been addressed.

The non compliances are discussed in the body of the report and included in the action plan at the end of this report. The provider submitted two versions of an action plan response however, they did not fully address all non compliances, and therefore were not accepted by the Authority.

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:
The inspector found that the layout of the premises, presented challenges for the maintenance of residents' privacy and dignity. Residents were not fully supported to make choices about their daily life. Activities are dictated by the routine and resources of the centre and not by the wishes of the residents.

There was some evidence that residents and relatives have an opportunity to contribute in how the centre is planned and run. The inspector found that resident's wishes were progressed to board level through the parents on the board of the centre.

Some residents gave examples of how they were involved in the running of the centre, for example, shopping for food and planning their own meals.

Some of the staff spoke about resident's involvement with their local community including, visiting family members, going to the local shops and going out for a meal with support.

The inspector found that the complaints policy met the requirements of the regulations; however it was not on display in the designated centre. There were no complaints available for review for the service.

Information on how to contact an external advocate was on display, however staff that supported residents were not familiar with this person or how to access the service.

While the inspector found that the majority of staff treated residents with respect and

dignity not all staff protected residents' privacy and dignity, for example, not knocking on bathroom doors prior to entering. This was discussed with the provider during the inspection.

Also due to the layout of the premises, staff did not maintain resident's privacy during the delivery of intimate care. Due to the size and layout of the multi occupancy bedrooms and bathrooms, dignity and privacy for all residents could not be maintained. Staff described that with the multi functional bathrooms in some of the houses residents used a toilet in a cubicle while other residents had a shower behind a curtain in the same room. This is outlined in outcome 6.

Due to the structure of the day, care was based on routine and not person centred. The resident's day was based on the availability of staff, and access to the day service and was not reflective of their needs or their personal plans.
Many of the staff spoke of lack of staffing attributing to the residents' lack of access to activities that are meaningful and purposeful and reflected their interests and capacities.

Support plans showed that staff facilitated residents to exercise religious rights. Residents were supported to visit the church regularly when they wished and also to access religious services of their choice.

There was a policy and set of procedures for protecting residents' property and monies; however they were not consistently implemented in practice. Staff support residents to retain control over their property and where small amounts of monies are held by the centre there is transparent procedures in place to protect both residents and staff. However, the inspector found that they were not consistently implemented by staff. Balances were checked and were incorrect for one resident, and money was not available to be checked for another resident as the small amount of cash was held by a family member. However, there were no records to reflect this practice. The inspector found that all entries were not always signed by two staff members or the resident in line with the policy.

Judgment:
Non Compliant - Major

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were systems in place to assess and meet residents' needs; however improvement was needed to ensure all residents' communication needs were met.

There was a policy in place that set out the importance of identifying and meeting residents' communication needs, and a system for identifying the level of support individuals needed. The staff who developed the policy explained that they were in the process of introducing new documents and assessments, and had a plan to put support systems in place for all residents who had communication support needs. At the time of the inspection this was not in place for all residents.

Some residents were seen to have communication passports in place that gave an overview of their communication style, and other key information people may need to know about them. However, the communication passports were stored with the secure file and were not being used by staff to interact with residents.

Information was available throughout the centre in accessible formats, for example menu choices were available in picture format in some houses to support residents in making a choice. However, this was not consistently on display in all of the houses in the designated centre. Many of the policies and guidance documents were provided in an easy read and picture format that would support some residents to understand them.

Residents had access to magazines, radio, television and a hands free telephone. However internet access was not provided to residents to enhance their communication. There was no assistive technology or aids and appliances available for any resident to support their communication needs and promote their full capabilities.

Some residents needed support around appropriate ways to communicate with other people and this was covered in their positive support plans. They focused on identifying what words residents may use to express certain feelings, and prompts for staff about how to respond in a range of circumstances. The plans were also seen to explain the possible causes for residents to communicate or behave in certain ways, and how best to support them during those experiences, including their environment.

Throughout the inspection the inspector saw that staff were communicating well with residents, and understood their individual ways of speaking and communicating.

Judgment:
Substantially Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that residents were supported to develop and maintain personal relationships and links with family and the wider community. This was in line with the goals of the organisation which was, 'to develop each person's full potential and ensure their long term well-being within a positive environment'. This was also outlined in picture and word formation as one of the 'residents rights' as outlined in the residents guide.

Residents' personal plans contained important information such as details of family members and other people who are important in their lives and information regarding residents' interests. Support plans set out the key relationships in residents' lives as part of their support network, and any support that was needed to maintain those relationships. There were records of the contact residents had with their family members and others.
The key workers told the inspector that they ensure residents have an opportunity to maintain close relationships with family members. For example they often contact family members to arrange a family meal out. The inspector noted that records of visitors received by residents were maintained.

An information booklet was available to visitors, describing the service and the visiting hours. A newsletter was also available, keeping family and friends up to date with recent events in the centre.

There were no relatives visiting at the time of the inspection. Some residents gave examples of how they are supported to develop and maintain personal and family relationships and maintain links with the wider community. For example, visiting their family home regularly and spending weekends and holidays with family, and going out for a social drink with support from staff.

The inspector observed residents on campus enjoying time with friends, family and their small children in the restaurant on campus. The premises were suitable to facilitate residents to meet friends and relatives privately if they wished and that staff respected their privacy.

Transport was available to staff to take residents out, and many residents told the inspector that they enjoyed the weekly disco. There was also a heated swimming pool on campus which residents could avail of with staff support. Some residents had enjoyed holidays abroad with the support of volunteers and/or staff members who know them very well.

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):
No actions were required from the previous inspection.

Findings:
There was an admissions policy in place, but it did not fully meet regulatory requirements. It did not outline the inclusion and exclusion criteria for admission or the nature of the assessment, care planning process or review. The admissions process did not consistently consider the wishes, needs and safety of the individual and the safety of other residents currently living in the services. The management team acknowledged this deficit and were committed to ensuring that the policy would be updated implemented and evaluated.

There was a contract of care in place to detail the supports, care and welfare of the residents in the designated centre. This was called the "memorandum of service provision". This was supported by a "manage my money" document. However the contract of care did not fully include the details of the services to be provided for residents. The inspector found that many of these agreements had not been signed.

Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
The assessments of each resident were not comprehensive enough to identity their health, personal and social care and support needs. This impacted on the quality of personal plans for residents and the level of care and support provided. The inspector reviewed a sample of six of the plans and found there was not a consistent approach to the development of the plans. The current model of personal plans did not support the development of current needs and choices of all residents.

The assessment did not have multidisciplinary input; there was not an assessment of need and therefore this did not inform the personal plans. Many of the staff spoken with were not aware of the residents' plans and they did not inform the service delivered. There was some evidence of reviews; however, it was not apparent if the goals set had been achieved. The provider had acknowledged the deficits in the documentation and had recently introduced a new planning document and staff had received training. The inspector found that when this would be introduced it would address many of the deficits identified.

The implementation of personal plans was dependent on availability of staff. The majority of residents had complex needs and required a high level of support to provide meaningful activities and promote a good quality of life. The inspector found that all residents were not consistently supported to engage in meaningful activities, particularly on the weekends.

Staff told the inspector that there were not always enough staff on duty at weekends or in the evening time to facilitate outings for residents. Staff confirmed that they were sometimes unable to take residents out as there was not always adequate staff on duty, or if staff were taken to cover other areas, residents' activities were cancelled. The inspector reviewed the activities records maintained for residents and noted that there was no recorded evidence that residents attended any activities on some weekends.

The provider had a day service in place on campus which a number of residents attended during the week. Staff explained that younger residents got involved in a number of leisure and social activities in day care and some residents gave some examples of activities they enjoyed such as going to watch sporting activities in the community with staff support (when staff were available).

The inspector found that the placement of residents who had retired, and some elderly residents with complex health care needs who attended the day service, was not appropriate.

The provider had identified a gap in meeting the social and retirement needs of these residents and he told the inspector that he was in the process of rolling out a model of supports for older persons taking into account pre-retirement and retirement options, while also taking account of residents' changing health care needs. The inspector found evidence that this model had worked well in Cheeverstown Community Services and that the residents on campus should also benefit from participating in this programme.

The inspector saw that there were records maintained in residents' files that the family

were involved in the multidisciplinary review with the residents' permission, if the resident requested this. The documentation of the involvement of families in multidisciplinary reviews on an ongoing basis could be improved.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The centre consisted of four houses located on the campus within close proximity of each other.The inspector found areas for improvement in all the houses but the physical environment in one house especially did not meet the requirements of the regulations.

There were significant deficits noted in some of the houses which impacted on the rights and dignity of residents. There were an insufficient number of showers and toilets to meet residents needs, and the location of some bathrooms and toilets and the multi occupancy rooms did not respect residents dignity. While these issues had been discussed at the property committee, there was no plan as yet in place to address the deficits in the premises.

House 1 and House 2.

The first and second house on campus are single story and are a replicate of each other. One of the houses has six bedrooms, to accommodate seven residents.There were seven residents living there on the day of inspection and five residents residing in the second house.

The house had multi occupancy bedrooms with four beds in one room and three beds in another room. There is a separate kitchen cum dining room, large day room and a relaxation room. As already discussed in Outcome 1, the multi-occupancy rooms were not suitable in terms of personal space and the privacy and dignity of residents. In order to reach the beds at the rear of the room it was necessary to walk past residents' beds located beside the door and through their personal space. There was very limited space between the ends of some beds which were facing each other, this impacted on

residents privacy and personal space.

The location and the lack of an appropriate number of bathrooms and assisted toilets impacted on residents privacy, dignity, choice and quality of life.

While there were a number of large sofas for residents to use, one of these was bottomed out and therefore not suitable to sit on. The standard of upkeep was poor. The walls and skirting boards were stained and unkempt in appearance. The net curtains were grey in colour and appeared dirty.

While some residents used urinals there is no bed pan washer in the house, and there was not a protocol in place for cleaning them. This presented potential risk for infection.

One of the houses had two multi occupancy, dormitory style bedrooms, each with four wash hand basins. Although the number of residents who shared the rooms had decreased , these bedrooms did not meet the need of the residents and did not maintain residents dignity. One of these bedrooms is reduced down to a three bedded room and the other bedroom is reduced down to a two bedded room. There was appropriate screening around each bed. However there is not much space in the bedrooms. Staff need to move one of the beds to provide assistance for one resident as one side of the bed is against the wall.

The other house has seven single bedrooms with a wash hand basin. There were five residents residing there on the day of inspection. All bedrooms are spacious, clean, decorated to a high standard. and personalised to the residents choice. There is adequate wardrobe space for residents clothing and personal effects. There is adequate wardrobe space for residents clothing and personal effects. All bedrooms have a television.

The location and insufficient numbers of bathrooms and assisted toilets in one of the houses impacted on residents privacy, dignity, choice and quality of life. The bathrooms are located off the living area where residents could be seen getting dressed. The bathroom consisted of a bath with a shower curtain, and a walk in shower, also with a shower curtain, a sluice, a ceramic sink, two cubicle toilets which are very narrow, and not wheelchair accessible. This impacted on one residents dignity as the resident could not access the toilet. Staff told the inspector that when one resident is having a shower, and another resident is having a bath at the same time that they ensure the shower curtains and the curtains around the bath are used.
There is a separate small kitchen/dining area and a staff office adjacent to the living room. This dining area was too small to accommodate residents.

There were residents with medical problems who require frequent and immediate access to the bathroom in one of the houses. As residents had access to only one bathroom this meant that residents may have to use these toilets when other residents are having a bath or shower.

Other facilities included a separate laundry room containing a washer and dryer and separate storage area for medical files.

There is a small sitting room with television and comfortable sofa next to the staff office, a spacious, homely sitting room cum dining room, with two tables, and good quality seating. There is a nice spacious kitchen and living area, nicely decorated, also homely and well maintained. There are hand rails along the corridors.

The fourth house is a two story two bedded house where one resident resides. Upstairs there is a spacious bedroom with wash hand basin, a bathroom with a bath, toilet and wash basin. The staff office is also located upstairs.

Downstairs there is a spacious nicely decorated sitting room, well equipped kitchen and a separate toilet with wash hand basin.

Some maintenance work is required; there was a hole in the bedroom door and the inside of the house required painting.

Houses were noted to have suitable levels of natural and artificial lighting, heating and ventilation.

Judgment:
Non Compliant - Major

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
The inspector found that the provider had put risk management measures in place; however, they needed to be significantly improved. For example, risks associated with fire safety, manual handling practices and the storage of chemicals. Infection control issues were also identified.

The systems for the identification, assessment and management of risk required improvement and measures put in place following adverse incidents to prevent them from recurring required improvement. The centre had policies and procedures relating to health and safety and these were seen in practice.

The inspector found that there was a Health and Safety Statement for each location, however this did not include the environmental issues in each house, it also did not include any risk assessments or any control measures to mitigate any risks. While there

was a corporate risk register, it did not include all risks associated with the location, for example, the staff number and skill mix.

While there was a new guidance document for infection control, there were no procedures in place for the cleaning of resident equipment between uses. The inspector found there was an absence of appropriate measures, such as hand sanitizer within the houses. The inspector also found that some of the medical devices such as the suction equipment were not cleaned regularly and there was dust seen on this equipment in one of the houses.

While there was a new risk management policy, which was revised from the previous inspection and information was provided to staff on the policy, staff were not knowledgeable in the management of risk or the completion of risk assessments. Staff told the inspector they would welcome additional training.

The inspector observed that residents could be placed at risk as they had access to cleaning chemicals as these were not stored securely.

The managers undertook a review of all incidents and accidents. A report was available on a three monthly basis. However this information was not being used in the houses to improve care for residents. While recommendations were identified they had not been consistently implemented. This information was not being fully analysed to improve the service, minimise the risk of future occurrences and this was a missed opportunity to share any learning for the period.

The inspector found that there were centre specific emergency plans in place that outlined the procedure for evacuation, contact numbers and location of main valves for electricity, water and gas. The inspector found that while the provider had put risk management measures in place; they needed to be significantly improved. For example, risks associated with fire safety, manual handling practices and the storage of chemicals. Infection control issues were also identified.

The systems for the identification, assessment and management of risk required improvement and measures put in place following adverse incidents to prevent them from recurring required improvement. The centre had policies and procedures relating to health and safety and these were seen in practice.

The inspector found that there was a Health and Safety Statement for each location, however this did not include the environmental issues in each house, it also did not include any risk assessments or any control measures to mitigate risks.

Clinical and environmental risk assessments were not consistently being carried out to inform appropriate care plans or action plans. This meant that areas of high risk may not always be identified and acted on, such as falls risk assessment and risk of absconding.

While there was a corporate risk register, it did not include all risks associated with the locations. While there was a new guidance document for infection control, the inspector found there was an absence of appropriate measures, such as hand sanitizer within the

houses. The inspector also found that some of the medical devices such as the suction equipment were not cleaned regularly and there was dust seen on this equipment in one of the houses.

Fire compliance
Overall fire safety required improvement. The inspector viewed the fire training records and found that staff had received up-to-date mandatory fire safety training and this was confirmed by staff. The fire procedures on display would not guide practice. Regular fire drills were carried out by staff at suitable intervals as defined by the regulations; however, the learning from the drills had not been addressed to promote improvement for future drills.

There was evidence that fire equipment was serviced regularly. There was evidence that the fire extinguishers, fire alarms and emergency lighting were serviced.

The inspector found that all fire exits were unobstructed on the day of inspection. While residents had individual evacuation plans, they were not consistently in line with the evacuation plan posted at the main door. For example, in relation to the number of staff required to evacuate individually named residents. The inspector also found that staff were not fully familiar with them.

The inspector noted that emergency lighting was not available in all of the houses. The provider was aware of many of the deficits and had an action plan in place to address the issues.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
The inspector found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. However, these required significant improvement.

The inspector found that residents were not fully protected from abuse; this included the management of residents' finances and staff assault. Residents' finances were not managed in line with the policy as per Outcome 1.

Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. The inspector found that fifty percent of staff had not received training on safeguarding vulnerable adults in the past three years. Further training was planned to include the national policy.

The policy on safeguarding residents from abuse contained guidelines on how any allegations of abuse would be managed. However, this was not detailed to include allegations against a staff member. The provider had appointed a designated adult protection officer. The responsibilities for this person were contained in the policy, and the officer was a resource to staff should they need to discuss any concerns they had.

Residents who spoke with inspectors, and completed the questionnaire for the Authority (Health Information and Quality Authority) all said that they felt safe live in the centre and with the staff.

There was evidence that incidents of all allegations of abuse were appropriately investigated.

The inspector found that not all staff protected residents' privacy and dignity. There were good procedural guidelines on the provision of personal care to residents including respecting residents' privacy and dignity. Each resident had an intimate care plan that set out their personal needs and how they were to be met. While the inspector found that the majority of staff treated residents with respect and dignity not all staff protected residents' privacy and dignity; for example, not knocking on bathroom doors prior to entering. Also due to the layout of the premises, staff did not maintain resident's privacy during the delivery of intimate care. Other example where residents' dignity was compromised is outlined in Outcome 6 and Outcome 11.

While here was a policy on the management of behaviours that challenged it was not been being used fully to guide the care delivered. There was also a new policy that had been approved and this was going to be circulated to staff. The new policy was strongly focused on the rights of residents, promoting positive approaches and identifying and addressing any causes for resident's distress.

Staff had received training on crisis prevention intervention but not specifically in the management of behaviours that were challenging, there were plans in place to provide training on the new policy and procedure. There was evidence that the General Practitioner (GP), psychology and psychiatric services were involved in the care as required.

There were behaviour support plans in place for all residents with behaviour that challenges. These were not reviewed regularly, were not up to date and did not consistently guide care. For example, one residents support plan referred to a resident having one to one support, however this had previously discontinued. The inspector

observed the resident to be distressed and while short-staffed, staff spent some one to one time with the resident. Staff told the inspector that while the resident's behaviour had improved the resident occasionally assaulted staff.

The inspector found that the use of restrictive procedures was minimal and where they were in place, they were reviewed by the rights committee and were proportionate to the risk. They included interventions such as having one to one staff support.

There was no restraint register for the centre to include all restraint.

The management team had reduced the use of bed rails since the previous inspection. Where residents were using bed rails, there were risk assessments completed, and the staff monitored the resident on an hourly basis. However this good practice was not reflected in their care plans.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that the staff had maintained records of all accidents and incidents that had occurred in the centre. These were reviewed by the nurse managers. The provider was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date and to the knowledge of the inspector, all relevant incidents had been notified to the Chief Inspector.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that residents' general welfare and development was being facilitated. However, this could be further developed.
Each resident had opportunities for new experiences, social participation and activities that matched their preferences. Factors that limited residents' access to activities at weekend were discussed under Outcome 1.

There was a policy on access to education and training. Educational and training opportunities were available to all residents, and residents were being supported to engage in learning opportunities. There was no broadband, therefore residents could not avail of e-learning programmes.

Records reviewed, and discussions held with residents and staff, confirmed residents had a variety of opportunities to engage. Each resident had their own weekly schedule that set out the range of activities they were involved in.

Residents who spoke with inspectors told of the different activities they took part in. This included attending a range of different day services, attending groups, classes, having jobs locally and volunteering.

Some residents explained they were semi-retired, and so spent more time in their homes, or accessing the local community rather than more structured activities, as mentioned in Outcome 3.

These were guided by resident's own interests and preferences and in some cases set out in their personal goals. The planning meetings between the residents and their key workers identified things residents wanted to achieve and some evidence was seen of these being met. It was noted that not all residents had goals identified for 2015, but work was ongoing for this, with more of a focus on charting their progress in achieving identified goals.

It was noted that an assessment of resident's skills, and where new skills could be developed would further improve their opportunities for independence.

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:
The inspector found that there were appropriate arrangements in place to support residents' health care issues as they arose. The staff in the houses were very familiar with residents' needs and identified changes in residents' condition promptly. Staff had created links with the health services within Cheeverstown allied health professionals. However healthcare assessments and care planning required improvement.

Evidenced based risk assessments were not undertaken for falls, nutrition, wounds and pressure area care prevention were not in place. There was also an absence of care plans for one resident with a wound and residents at risk of falls. Where one resident had four falls, there was no recorded evidence that a reassessment had been completed after each fall to reduce reoccurrence. Residents were not always reviewed by the doctor following a fall, and this could result in poor outcomes for residents.

There was delayed, and sometimes no follow through on referrals to other services. There were no consistent records maintained in the resident's file of follow through when the need for referrals to other services was identified, for example, cataract surgery recommended two years previously. There was no record maintained of the plan in place for the resident to have the surgery. While residents were referred to and reviewed at the complex needs committee, there was insufficient evidence of the follow through from this meeting. Staff were unable to tell the inspector if referrals were made and when appointments were due.

Staff told the inspector that a resident had an assessment by the occupational therapist who recommended a low-low bed. However, this documentation could not be located and the bed was not delivered until one year later.

While residents had guidance documents in place for epilepsy, and dysphagia, there was a lack of care plans in place to guide staff. The epilepsy guidance documents were generic and did not guide the care for all residents.

The monitoring and checking of emergency equipment required improvement, as discussed in Outcome 7.
Safety plans for residents were not consistently reflective of the current health needs of residents.

The inspector reviewed the personal plans and medical folders for six residents.
They had access to a general practitioner (GP), including an out of hours service. There was evidence that residents accessed other health professionals such as chiropodists, opticians, physiotherapist and occupational therapist.

Overall, there was a lack of evidence that health assessments were completed. Health plans were in place for all residents; however they were not consistently up to date for all residents. They did not reflect the assessed needs of residents. Many were not updated or followed up on, for example monitoring therapeutic bloods for residents on medication and provision of flu vaccinations to elderly, compromised residents.

Records were not maintained in accordance with professional guidelines, for example white-out corrector fluid was used on documents, and while notes were dated they were not timed using the twenty-four clock.

Overall residents appeared to enjoy their evening meal when they returned to the centre. In some houses this was an appropriate dining experience where residents decided what they wanted for their evening meal and if any resident did not like what had been prepared, there was a range of alternatives available. Residents were supported to have a snack at any time of the day or night if they preferred.

The inspector found that there was an ample supply of fresh and frozen food. Fresh fruit and juice was available during the day which residents could access. Residents enjoyed going out for a meal at times.

There was not enough staff on duty to provide appropriate assistance or supervision at meal times. The breakfast experience in one of the houses required significant improvement. Residents at risk of choking were not appropriately supervised; one resident was unsupervised for 90 minutes while having breakfast. Staff were observed to be standing over residents assisting them with a meal. The meal time was hurried, and not a pleasant social experience. Staff were rushed trying to get residents ready for day services.

Assistive devices such as plate guards and adapted cups and cutlery were provided to residents to promote independence at meal time.

The dining area was small in one of the houses. There was no appropriate dining space for some resident who sat in a small dining area with one staff member to provide the meal.

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):

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

Findings:
The inspector found that there were some good processes in place for medication management with some areas for further improvement to ensure consistent safe medication management practices.

The inspector reviewed the medication management policy and found that it met the requirements of the regulations. It provided guidelines relating to the ordering, prescribing, storing and administration of medicines to residents. Staff were familiar with the policy, and were knowledgeable about residents' medications.

Staff were trained to administer medications and inspectors found they were knowledgeable about safe administration of medication. Inspectors reviewed the prescription record and medication administration records for residents and found that the documentation was complete. Where medications were prescribed as required (PRN) the maximum dose was prescribed, for example paracetamol for pain relief.

All residents' medications were reviewed three monthly by the doctor.

The inspector observed that the medication storage cupboard was in the staff office. The keys were kept with the senior person on duty and the locked cupboard was used solely for the purpose of medication storage.

Some residents go home on a regular basis, and there were arrangements in place for sending the correct medication with the resident.

There was a procedure in place for counting and recording the number of medication administered and remaining. There were also clear guidelines on the administration of injections. For example, only a registered nurse was allowed to administer injections, including insulin.

Inspectors observed that there were appropriate procedures for the handling and disposal of unused and out of date medicines in line with the policy.

Medications were obtained from the pharmacy weekly or twice weekly as required and there was a system in place for recording all medications taken from the pharmacy.

Staff told inspectors that the pharmacist was available to provide advice as required, for example in relation to what drugs may be crushed as prescribed, or alternatively provided in liquid format.

Information pertaining to each resident's medication was available in the resident's files. Staff knew about the procedures for reporting medication errors. While a medication audit for the service was completed, staff were not aware of the findings or if any improvements were needed.

Medication audits were not completed for each location to identify areas for improvement; therefore there was a missed opportunity for learning.

There were no medications that required strict control measures (MDAs) in place during the inspection. The inspector found that the space on the chart to record allergies was frequently left blank.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
The inspector found that the Statement of Purpose did not fully meet the requirements of the regulations. It reflected the centre's aims, ethos and facilities. It did not fully describe the care needs that the centre is designed to meet, as well as how those needs would be met. The room sizes were also not included.

Feedback was provided to the management team on the deficits in this document.

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):
No actions were required from the previous inspection.

Findings:
The inspector found that while there was a management team in place, there was no person in charge nominated to oversee the management of the designated centre. This concern was brought to the attention of the provider, director of services and senior management during the inspection. They are aware of their requirements under the Act and the Regulations.

The inspector found that there was a lack of clinical governance in the centre which resulted in poor outcomes for residents. The inspector identified non compliances in the areas of clinical leadership health care, risk management and staffing arrangements as discussed in Outcome 11 and 17.

The inspector found that the provider had failed to ensure the arrangements provided sufficient oversight of key areas such as dignity and privacy, fire safety arrangements, risk management and healthcare issues as discussed throughout this report.

There was a senior management team in place. The team included the provider, director of service, assistant director of services, medical director, financial controller, operations and quality manager, human resources manager, employment and training manager. The provider was in the process of planning retirement and a new interim provider met with the inspector during the inspection.

A team of nurse managers provided oversight for the day to day running of the centre, and the service was in the process of a management review. The provider assured the inspector that a programme of supervision and mentoring was being planned for nurse managers. However, in the interim, the lines of accountability and responsibility for the provision of the designated centre at service level were not clearly defined or effective. While clinical nurse managers were in post, there was a lack of supervision and support for staff in the designated centre to ensure that the needs of residents are met; incidents are responded too, personal plans implemented and staff supervised. Nurse managers told inspectors that due to the lack of nurse managers in one area, they visit the house once per month.

The provider had established weekly clinical nurse manager meetings and overall weekly staff meetings were held in each location. While staff said they have access to the nurse managers by phone, the management style was reactive rather than a planned approach to the management of the service.

The provider had undertaken reviews of the service and an action plan was provided to the inspector. The management team were working through the action plans from the previous inspection. The centre had been externally accredited for quality.

While clinical data was collected, it was not being utilised to improve the service. There were no audits available for review. This was a missed opportunity for learning and quality improvement.

Managers explained to the inspector that they generally could only deal with issues on a day to day basis, as there was only one manager on duty to oversee the designated

centres. Much time was spent reallocating staff and booking relief and agency staff to cover staff leave. The director of services explained that a recruitment process is currently in operation.

The provider carried out unannounced visits to the centre, and the reports and actions plans from the visits were read by the inspector. However, there was no overall annual review of the safety and quality of the service as required by Regulations.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was no nominated person in charge of the designated centre as required by the regulations. This is discussed under Outcome 14 and the relevant action plan is also under Outcome 14.
The inspector also found that arrangements in place for the management of the designated centre were inadequate.
There was a team of committed and knowledgeable clinical nurse managers employed. However due to their case load they were unable to visit the designated centre frequently in order to monitor the quality of service delivery or to provide a consistent level of supervision for the staff working there.

Judgment:
Non Compliant - Major

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that there were insufficient resources to meet the needs of residents. There were insufficient staff on duty at times and resources had not been made available to improve the layout of the houses in order to meet the resident's needs. Please see Outcome 6 and 17.

Not all residents had timely access to specialist equipment to meet their assessed needs, for example, wheelchairs and a low-low bed. A hoist had been broken for six months and not replaced to transfer residents into bed safely. Staff told the inspector that they assisted the resident into bed manually; this was contrary to the resident's manual handling assessment. The inspector was concerned that this could result in poor outcomes for residents and staff.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
The inspector found that overall there was a very committed and caring staff. Staff knew the residents well. However the staffing levels and skill mix were not enough to meet the needs of residents. The provider told the inspector that he was actively recruiting new staff to address the deficits.

There was an inappropriate allocation of agency staff. The inspector observed an oncoming and an outgoing agency staff on their first day in providing one to one support for a resident. The resident was not familiar with these staff. There was no permanent staff member available to ensure the hand over provided was adequate to meet the residents' needs. The agency staff member told the inspector that they had not been informed of the managements contact details from the outgoing staff member

should they required advice or support.

The inspector found that the provider had established a relief panel since the previous inspection, with an aim of providing a consistent service to residents. However the folders which they were to refer to regarding the residents' needs did not set out the residents' needs in one of the houses.

The inspector found that the staff number and skill mix was not consistent to meet the changing needs of residents with health care issues. The inspector found that staff were frequently moved from two of the houses to other houses when there was a staffing deficit in another area. Staff told the inspector that they would not always be familiar with the residents in other houses where they administered medications. The inspector was concerned that this could result in poor outcomes for residents in both houses.

Nurse managers confirmed that the staffing number was based on historical data and not on the assessed needs of residents. In one location residents' outings were cancelled if there were not enough staff on duty. There was no process to capture this information, therefore management were not aware of the scale of the problem.

Staff files were reviewed and contained all of the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. This had been identified at the previous inspection and was addressed.

While performance reviews were in place, as previously stated the supervision of staff required improvement. The follow through of the training needs identified were not always in place.

Training records were reviewed by the inspector. There were some gaps noted in the mandatory training (fire response training, moving and handling of residents and prevention and awareness of abuse). However the provider was aware of these gaps and inspectors reviewed a schedule of training which responded appropriately and in a timely fashion.

There were a large number of volunteers and external service providers who provided a valuable service to residents within the large organisation. There was evidence of vetted by An Garda Síochána and a written agreement of the role of the volunteers in the centre.

While staff had access to training, they were not kept up to date on residents' specific clinical issues. Staff had not received recent training on medication management, infection control, nutrition, altered consistency diets and swallowing difficulties, management of diabetes, restrictive practices, risk management, example cardiopulmonary resuscitation (CPR), infection control and end of life care.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that policies were in place as required by the regulations. However, improvements were required to ensure the policies guided practice and were implemented, audited and updated as required.

The inspector reviewed policies and found that a number of policies did not contain an implementation date, review date and had not been signed as approved by management. Some of the policies in place had not been rolled out, and staff had not received training in a number of the policies. As a result staff were not familiar with all of the policies.

There was no centre specific policy on infection control guidelines. The inspector was concerned that this could result in an inconsistent approach to the management of infection control issues, for example such as the procedure in place for cleaning equipment. There were no cleansing gels in place for visitors or staff to clean their hands to minimise risk of infection.

The end of life care policy was not comprehensive; it did not outline arrangements such as management of residents' possessions and information regarding preferences for funeral arrangement and place of burial.

The risk management policy did not guide practice as outlined in Outcome 7 and Outcome 12. For example, clinical and environmental risk assessments were not consistently being carried out to inform appropriate care plans or action plans. This meant that areas of high risk may not always be identified and acted on, such as falls risk assessment and risks associated with smoking.

Staff also required additional education and training and supervision to ensure all policies were implemented in practice, for example the risk management policy.

Residents' records were not maintained in line with best practice. The time of the entry was not documented and fluid had been used to erase some entries.

An up to date insurance policy was in place for the centre which included cover for residents' personal property and accident and injury to residents in compliance with all the requirements of the regulations.

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 report[1]

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004926
Date of Inspection:	21 and 22 April 2015
Date of response:	18 June 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the layout of the premises, care was not provided in a way that respects residents' privacy and dignity.
Not all staff respected the privacy and dignity of residents- for example knocking on bathroom doors.

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 (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 action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Access to activities was dependent on availability of staff and access to day services rather than the wishes and needs of the residents.

Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy was not displayed in the centre.

Action Required:
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
The accessible version of the Complaints Procedures will be on display in each residence; this will include a picture of the Complaints Officer, contact details and details of the Appeals Process.
The full Complaints Policy is also available in each house but not on public display

Proposed Timescale: 30/06/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Communication passports were stored in a secured file and not available for staff.

Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
All Communication Passports will now travel with the person between residential and day care services and will be available to all support staff.
Ongoing & 31st July 2015

Proposed Timescale: 31/07/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract of care did not fully include the details of the services to be provided for residents

Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each 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:
The service will ensure that the agreement for each resident (Memorandum of Understanding) is in line with the regulations.
In this regard the Memorandum of Understanding will state the amount of each resident's long stay charge following their assessment

Proposed Timescale: 30/06/2015

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:
Assessments did not have multidisciplinary input

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:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessments of each resident was not comprehensive enough to identity their health, personal and social care and support needs.

Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The level of care and support provided varied and did not consistently reflect each residents' personal plan

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:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The were insufficient numbers of showers and toilets to meet the needs of residents.
The location and layout of bathrooms and toilets did not not support the dignity of residents.
Multi occupancy bedroom rooms did not not support the dignity of residents.
The limited space between beds and the layout where residents faced each other did not respect residents' personal space or privacy

Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The walls and skirting were stained and not appropriately maintained.
The sofa was bottomed out and not suitable for use.
Net curtains were grey and appeared dirty.
The fourth house had a hole in the bedroom door and required painting.

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:
A schedule of maintenance and redecoration has been set out

Proposed Timescale: 31/08/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The monitoring and checking of emergency equipment required improvement. While oxygen was available in one house there was not an effective system of regular checks to ensure it was readily available for use in an emergency. There were no appropriate suction attachments for the suction equipment and this equipment was not checked to ensure it was in working order in the event of an emergency.

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:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Data from incident and accident records was gathered but not used to improve safety and prevent a reoccurrence

Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Clinical and environmental risks were not carried out to inform care plans and action plans.

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:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Health and Safety statements for each location did not include the environmental issues in each house. It did not include any risk assessments or control measures to mitigate risks.

Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no procedures in place for the cleaning of resident equipment between use. Suction machines were dusty and there were inadequate hand sanitizers.

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 action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Individual evacuation plans ere not consistently in line with the evacuation posted in the main hall.

Emergency lighting was not provided in all houses.

Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Behaviour support plans were not reviewed regularly, were out of date and did not consistently guide care.

There was no restraint register for the centre to include all restraint.

Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Safe Services

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

50% of staff had not received training on safeguarding vulnerable adults in the past three years.

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:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' finances were not managed in line with the policy.

The policy did not include details if there was an allegation against a staff member.

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:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents did not have timely access to external health care services or specialist equipment.

There was no system to ensure that emergency equipment was maintained and available for use.
It was not evident that health assessments were completed.
Safety plans did not consistently reflect the current health care needs of residents.

Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each

resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not provided with appropriate assistance or supervision at meal times.

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:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose did not fully meet the requirements of the regulations

Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 14: Governance and Management
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** There was no person in charge nominated to oversee the management of the designated centre. **Action Required:** Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre. **Please state the actions you have taken or are planning to take:** The Person In Charge has now been appointed and the service is processing the necessary paperwork for submission to the registration department in HIQA **"AT THE TIME OF REVIEW THE DOCUMENTATION WAS NOT RECEIVED BY THE AUTHORITY"**
Proposed Timescale: 12/06/2015
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The lines of accountability and responsibility for the provision of the services at the designated centre were not clearly defined or effective. There was no overall annual review of safety and quality of the service as required by the Regulations. **Action Required:** Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. **Please state the actions you have taken or are planning to take:** "The action plan submitted by the provider does not satisfactorily address this failing identified in this report".
Proposed Timescale:

Outcome 16: Use of Resources
Theme: Use of Resources **The Registered Provider is failing to comply with a regulatory requirement in**

the following respect:
The inspector found that there were insufficient resources in the centre to consistently meet the needs of residents.

Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staffing level and skill mix were not enough to meet the needs of the residents.

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

Please state the actions you have taken or are planning to take:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Agency and relief staff were not familiar with residents and had insufficient information to provide consistent care.

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:

A recruitment campaign is ongoing to fill vacancies and to enhance the relief panel within the employment control ceilings imposed by the Service Level Agreement with the HSE; this will reduce the dependency on agency staff.

In the meantime the service will review and update the relief agency folders to ensure sufficient information to provide consistent care to residents is available to agency and relief staff
Relief folders updated: 31st July 2015

Proposed Timescale: 31/07/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were some gaps noted in the mandatory training and staff had not received training or updates on relevant clinical issues.

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:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Arrangments for the supervision of staff were inadequate.

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:
"The action plan submitted by the provider does not satisfactorily address this failing identified in this report".

Proposed Timescale:

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies were not consistently implemented. For example the risk management policy
Policies did not contain an implementation date, a review date and had not been signed by management.
There was no centre specific guidelines or policy on infection control
The end of life policy was not comprehensive

Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures 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.

Please state the actions you have taken or are planning to take:
Policies on protecting resident's property and monies will be implemented consistently.
The service has opened individual bank accounts for people in their own name.
The system to implement the roll out of these bank accounts to residents will be in place by mid July 2015
The service will cease to hold money on behalf of residents unless specifically requested to do so by 30th September 2015

Proposed Timescale: 30/09/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a policy and procedures for protecting residents' property and monies; however they was not consistently implemented in practice.

Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures 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.

Please state the actions you have taken or are planning to take:
Policies on protecting resident's property and monies will be implemented consistently.
The service has opened individual bank accounts for people in their own name.
The system to implement the roll out of these bank accounts to residents will be in place by mid July 2015.
The service will cease to hold money on behalf of residents unless specifically requested to do so by 30th September 2015

Proposed Timescale: 30/09/2015