

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004924
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Limited
Provider Nominee:	Paula O'Reilly
Lead inspector:	Anna Doyle
Support inspector(s):	Michael Keating
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:
10 November 2015 10:00	10 November 2015 18:00
11 November 2015 12:30	11 November 2015 15:30

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 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

The purpose of the inspection was to assess compliance with the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards of Residential Services for Children and Adults with Disabilities. Inspectors also followed up on the 33 actions required at the previous inspection in April 2015. Inspectors met with residents and staff, they also observed practices and reviewed documentation such as care plans, complaints logs, risk assessments, minutes of meetings and staff training records.

Inspectors found that a new person in charge had been appointed and some of the actions from the previous inspection had been completed, while others had been progressed, there was still significant improvements required. Inspectors did however review evidence of action plans that had been developed to address areas

for improvement and recognise that this is a work in progress. The governance and management outcome had a major non compliance. There was no report on the safety and quality of care to residents and unannounced visits to the centre by management did not generate action plans to support service improvements.

The designated centre comprised of a community home, and three campus based residential units. At the previous inspection one of the residential units had been a respite facility for children and young adults. This was temporarily closed as the unit was being used to facilitate residents from other units that were being renovated as part of the service plan. Staff were observed to treat the residents in a patient, respectful and friendly manner, and were knowledgeable of their health and social care needs. There was good access to medical, pharmaceutical and a range of allied health professionals.

A number of actions from the last inspection appear again on this report as they had not been progressed and completed. These and all other matters are outlined in the report and action plans at the end of the report.

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:

Overall inspectors found that some improvements had been made since the last inspection; however there were still areas that needed to be addressed.

Staff members were observed to be very respectful of the residents and while efforts had been made since the last inspection to protect residents' privacy in relation to personal care, the layout of multi occupancy rooms and bathrooms in two of the units in the centre did not maintain resident's dignity and respect. However one other unit had recently been renovated and plans were in place by the provider to renovate all units within the designated centre. This is discussed under Outcome 6. In addition inspectors noted that some information about residents was not communicated privately by staff. For example guidelines to support individual residents were posted on the wall in the bathrooms.

The centre was managed by staff with little consultation from residents. There were no regular house meetings taking place in any of the units. Staff told inspectors they consulted with residents about their food choices after completing the weekly house shop each week. There were pictorial menus displayed in the kitchen, however there was no written evidence of this consultation.

The complaints policy was in an accessible format and was displayed in the centre. Staff were aware of who the complaints officer was and residents had access to an independent advocate if required. One resident attended advocacy meetings within the centre on a monthly basis. A complaints log was maintained in the local manger's office and while all complaints were logged, there was no evidence of the action taken to

resolve the issues and whether the complainant was satisfied with the outcome.

Finances were still being maintained centrally in an administration office. This was an action from the last inspection. However the finance officer advised inspectors that all residents now had their own bank accounts, and debit cards for these were being kept securely in the office. The cards would be distributed as soon as the residents' disability allowance was paid into these new accounts. New financial ledgers had been drafted for each resident in the designated centre. This would clearly log each update to the resident's savings, current account, post office account and personal possessions. The ledger would be double signed and kept by the service user. The finance office will conduct spot checks of these ledgers and is currently liaising with the bank on how to review these against the bank records in a way the best respected data protection. Inspectors viewed a sample of finance records on the day and found balances to be correct, however one receipt showed that a resident had paid for two meals on a receipt for the same transaction. Staff assured inspectors that this would be followed up and rectified. There was a system in place for night staff to audit residents' finances every week.

The religious rights of residents were maintained and inspectors were informed that a local priest visits the centre to say Mass for residents. Inspectors were informed on the first day of the inspection that residents were attending Mass that evening in the centre.

Judgment:

Non Compliant - Moderate

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:

Since the last inspection the admissions policy and contract of care had been reviewed however, both areas required further improvements.

The admission policy had been reviewed in March 2015. On reading, inspectors, found it did not reflect the inclusive admission and transfer process practiced in the centre. For example, it did not state that residents and their next of kin were invited to visit the house, meet the residents, stay overnight and were involved in the re-decoration of their personal space prior to their admission.

There was a contract of care in place called 'memorandum of service provision'. It included written and pictorial information regarding the services and facilities provided. However, it did not detail what utilities or access to which members of the allied healthcare team were included in the monthly fee stated. In addition, it did not outline what additional charges could be charged to the resident. The document was signed and dated by the resident or their representative however; it was not signed by the provider, person in charge or a representative from the organisation.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Inspectors found that a comprehensive assessment of the health, personal and social care needs of residents had not been carried out. This had been an action from the previous inspection and inspectors found that the new care plans viewed at the last inspection had not been implemented as yet.

Residents had access to allied health professionals including occupational therapy, speech and language, palliative care nurses. However in some plans there was no evidence of how allied health professional recommendations had been introduced into practice. This is discussed under Outcome 11.

A number of care plans were reviewed at the inspection. Residents' plans were not in an accessible format. Residents had some social care needs being met, however the goals were very basic and did not consider promoting the independent living skills of residents. Examples of some goals documented included 'using my walker', 'visiting my dad' and 'bowling once a month'.

Inspectors also found little evidence to support whether these goals had been achieved or reviewed. Goals that were been tracked had significant gaps in the documentation.

For example one resident who had an activities sheet to be completed daily had no activities documented for 21 days in a one month period. Another resident had a 'goal tracker progress sheet' to review set goals on a monthly basis, this had not been completed for three months.

Inspectors observed residents being accompanied by staff to activities based on the campus during the day. Some residents had visual timetables for activities displayed. One resident was supported by a day service staff a number of days a week. They provided 1:1 support for activities in the unit. The staff were led by the wishes and choices of the resident each day on what activities they wanted to do. However it was not always possible to support this resident with goals outside the unit as it required additional staff that were not always available. This is discussed under Outcome 17.

Judgment:

Non Compliant - Moderate

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:

Overall inspectors found improvements in this area, inspectors recognise that renovation work has begun to address the issues outlined in the last inspection report.

The centre comprised of three residential units and one community house that was located in a nearby suburb. Inspectors visited all premises on the first day of the inspection. The community house was in the process of having some renovation work completed. This involved renovating a room to create more communal space for residents.

One of the residential units within the centre had been renovated and the provider had plans to renovate the other two units within the centre on a phased basis. Inspectors reviewed the renovated premises and found that the work carried out was adequate to meet the needs of the residents. The centre was clean, suitably decorated and well maintained. There were adequate communal areas for residents to receive visitors. All residents had their own bedrooms that were large enough to have double beds if they required them. There were adequate storage facilities for residents to store their personal belongings. Each bedroom had hand basin facilities and privacy locks on the

doors. Tracking hoists were in place as required. Once the renovations work were complete two of the units would have six single occupancy bedrooms, this would change the occupancy levels in both of these units. This is discussed under Outcome 13.

Residents had access to appropriate moving and handling equipment which promoted their independence and there were very clear moving and handling guidelines for staff to support residents with this.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Overall it was found that the health and safety of residents, visitors and staff was promoted. However improvements were required in the area of risk management and fire precautions for the centre.

There was a risk management policy in place, however areas of this were not always implemented in practice. For example some environmental risks were seen by inspectors however there was no risk assessment on the storage or maintenance of oxygen in the centre. This was discussed with the manager on duty on the first day of the inspection. Residents had individual risk assessments in their personal plans along with an individual safety plan that summarised risks for the resident. However one resident's file did not have a risk assessment on absconding or self harm. Another risk assessment viewed by inspectors on the use of chemical and physical restraint for a resident did not have the measures to be actioned in their care plan and the review date was not timely.

While no risk register was in place inspectors were shown evidence of how the provider is in the process of implementing a comprehensive risk register for the centre.

Inspectors reviewed new risk register folders which made satisfactory reference to environmental and health and safety risks on a unit house level, including risk rating by impact and likelihood, and control measures for mitigation. These risk registers were due to be rolled out in selected house within the next few weeks, with registers for all houses completed in the next few months. The director and assistant director of services advised inspectors that there will be spot-checks to ensure the risk register is discussed at staff meetings, and that the registers will be reviewed as needs require and at minimum annually.

Inspectors were walked through the system for collating and analysing information received via the risk management incident forms. The information and reports generated provided clear incident numbers and trends arising for individual residents and within each unit of the designated centre, for example, times and notes from escalated behaviours identifying triggers and times of higher risk.

Inspectors were advised that the provider nominee and the head of the service improvement team had visited each of the units to conduct safety audits, and that these would inform the next annual report.

There were adequate precautions in place against the risk of fire in the centre. Fire evacuation procedures were prominently displayed. The fire equipment was adequate and serviced on a regular basis. Fire drills were carried out regularly however inspectors found that the learning from fire drills was not always discussed. For example inspectors viewed two fire drills where issues had been highlighted. One fire drill showed good evidence of follow up and additional staff members had been employed to ensure a safe evacuation for residents. However the other fire drill record viewed did not reflect the learning from the issues raised. This was discussed with the provider on the first day of the inspection. In addition it was found that staff members were required to leave the centre to assist with the fire evacuation of other centres at night. Inspectors met with the service provider, who was not aware of this practice and assured inspectors that they would address this concern.

Inspectors noted that there were no fire doors in some of the units. However the service provider had plans in place to address this. Completion of all fire doors is expected by March 2016. There was one area within the two of the centres that required further assessment by the provider with regard to fire containment in the kitchen area. There was no infection control policy in place to guide staff however inspectors observed good practices from staff. Hand hygiene facilities were in place and towels were colour coded for each resident.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

implemented.

Findings:

Overall inspectors found that there were measures in place to safeguard residents and protect them from the risk of abuse. This had been an action from the last inspection.

There was a policy in place for the prevention and detection of abuse. Staff were aware of what to do in the event of a resident suffering abuse. The provider held safeguarding meetings including peer to peer abuse, to discuss concerns and these were viewed in residents' files. However it was not clear from the policy who was responsible for reporting incidences of suspected abuse. Training records also showed that seven staff had not completed training in the prevention of abuse. However there was evidence that this training was scheduled to take place on the second day of the inspection and in December 2015.

There was evidence of clear positive support plans in some residents' personal plans. However some support plans were not comprehensive enough to guide practice. For example, one resident's plan gave a very comprehensive review of behaviours in a hospital passport, but this was not reflected in the support plan and there were no protocols to guide staff.

While there were risk assessments in place on the use of restrictive practice and protocols to guide staff on their use it was not evident how often they were reviewed and what the impact was for other residents. For example there were a number of locked doors in the centre to safeguard one resident. It was not reflected in other residents plans how this impacted on them and what measures had been taken to reduce impacts if any for those residents.

Inspectors found some good evidence of intimate care plans in place to respect residents' dignity when they were supported with personal care. However some plans did not guide practice so as to maintain a resident's dignity. For example one resident who was transferred from their bedroom to the shower room via a shower chair did not have this detailed in their care plan. It was also not evident from intimate care plans how residents were supported to maintain and increase independent living skills in this area. This is discussed under Outcome 5.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

implemented.

Findings:

Inspectors found that in general residents' health and social care needs were met. However significant improvements were required in documentation and review of healthcare needs.

Inspectors reviewed a number of care plans in the centre and found that residents had regular access to allied health services such as speech and language, occupational therapy, psychology and psychiatry where required. Inspectors saw good examples of moving and handling procedures for residents to guide staff. However one resident's file did not give guidelines on the treatment recommended by a speech and language therapist from their last appointment and staff could not provide inspectors with this information when it was requested.

While staff were very knowledgeable about residents' healthcare needs, care plans did not include a comprehensive assessment of all healthcare needs and did not have health action plans to guide staff. This was a finding from the last inspection, however inspectors did view a new healthcare plan that was being implemented in all areas of the centre that would address this issue. This is discussed under Outcome 5.

Inspectors also noted significant gaps in the documentation of residents needs. For example weight charts, records of behaviours and pain scale assessment tools were not completed in a consistent manner. This is discussed under Outcome 18.

Inspectors did not directly observe a mealtime during the inspection but did see evidence of pictorial meal planners for residents. All residents' meals were prepared on site in the centre with the exception of one resident who required smaller meals more frequently throughout the day. Staff spoken to informed inspectors that they liaise with catering staff to ensure that the residents' likes and dislikes are addressed when planning meals.

A range of food, snacks and drinks were seen to be available in each of the houses, and staff confirmed they shopped regularly and purchased food that reflected the tastes of the residents in the house. Some residents also enjoyed going out for meals.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Medication practices were sampled in a small number of units in the campus. The medication policy was reviewed and found to meet best practice requirements. There was a pharmacy technician on site to support staff and residents.

Inspectors reviewed a sample of prescription and administration records and saw that they complied with good practice. Medication was individually prescribed and good practice was observed in providing residents with alternative forms of medication where necessary.

In centre 1 a separate fridge for the storage of additional foods was observed by inspectors to contain medications stored in an unlocked container. Although staff assured inspectors that this storage area always remained locked it was observed by inspectors to be opened for periods during the inspection and therefore the medications were not securely stored.

There were appropriate procedures for the handling and disposal of unused and out-of-date medicines. Staff knew about the procedures for reporting medication errors.

Controlled drugs were stored in two units within the designated centre, while inspectors observed good practice in one of these units, the other unit only checked controlled drugs on the days of administration of the drugs, which in this case was every three days.

There was evidence of medication audits taking place, however staff were not fully aware of the findings and improvements required.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Overall the statement of purpose accurately describes the services provided but does not contain some of the information as required under Schedule 1 of the Health Act. The total staffing compliment in full time equivalents was inaccurate. For example clinical nurse managers were recorded as being employed in part time posts when they were in full time positions.

Information in relation to the current amount of residents residing in the centre was not up to date. Information submitted by the provider after the inspection showed that one of the units had been changed from a five to a six occupancy unit and that once the

renovation work was complete another unit would change from a seven to a six occupancy unit.

In addition the emergency procedures for the designated centre were not outlined in the statement of purpose.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Since the last inspection a person in charge had been appointed and inspectors found improvements in this area. However there were still significant improvements required under governance and management structures within the centre.

Inspectors found the systems in place to support the person in charge were not adequate. A nurse manager was deputising in the absence of the person in charge as other managers of the centre were on leave. The nurse manager was overseeing the designated centre, but was also responsible for another two designated centres on the morning of the first day of the inspection. Inspectors observed the manager in the centre on the first morning of the inspection but they were primarily located in administration offices. The nurse manager had only recently been appointed, however they had no formal induction to the centre. While they support and advise staff in all designated centres on the campus, it was unclear what their roles and responsibilities were in the designated centre they were working in. Inspectors found this arrangement was not adequate and it was evident this was having a negative impact on the quality of the service as evidenced during this inspection.

The centre was operated by the Cheeverstown House Limited. There was a senior management team which included the provider nominee (manager of quality and strategic planning) who was new to the role since 2 November 2015. In addition, the director of services, assistant director of services and others heads of department within the organisation were on the team. However, within this management structure the

lines of authority, accountability and responsibility for the provision of the service at centre level were not clear. Inspectors were not satisfied that the governance and management arrangements provided an adequate level of supervision of care and practice in order for the centre to be in full compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. This was supported by the findings of this inspection, with examples as follows:

- residents' files and information would not guide staff practice,
- healthcare plans were not developed for residents identified needs,
- fire safety deficits identified in the centre were not fully addressed,
- the management of risk was not effective,
- there was inadequate evidence of a systematic process for the on going review of quality and safety in the centre,
- staff were not formally supervised,
- managers overseeing the centre were not fully supported in their role,
- there were no lines of authority clarified at unit level in the centre

Inspectors read a report of one unannounced visit to one of the units in the centre. The findings were outlined in the report, however, the action plan did not consistently address the findings and there was no identified person responsible to address the identified issues. This was discussed with the provider who assured inspectors the findings were discussed in detail at person in charge meetings and the documentation of the reports would be reviewed to contain more detail. It was expected to complete unannounced visits of all units in the centre before the end of the year.

There was no overall annual review of the safety and quality of the service as required by Regulations. This was action at the previous inspection and was not addressed.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The provider nominee was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days.

The provider nominee had appropriate contingency plans in place to manage any such

absence. There were three nurse managers available to cover absences of the person in charge. These persons were all on leave during the inspection. A nurse manager was deputising in these persons absence during the inspection.

Judgment:
Compliant

Outcome 16: Use of Resources

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

Theme:
Use of Resources

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

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

Findings:

Since the last inspection, significant improvements had been made in this area. One area still needs to be addressed in terms of meeting residents social care needs. This is discussed under Outcome 5.

Overall inspectors found that the necessary staffing levels were employed within the designated centre, however it was difficult to assess from the documentation whether all social care needs were being met. An annual review of the service is to be completed, which should identify any shortfalls.

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:

Inspectors found that there was an appropriate number of staff and skill mix to meet the needs of the residents on the day of inspection. However improvements were required in the governance and management structures within the centre. This is discussed under Outcome 14.

Staff were knowledgeable of the residents and their needs and inspectors observed staff interacting with residents in a friendly and patient manner. Inspectors found staff were knowledgeable of the policies and procedure which were available to them in the centre.

Inspectors found evidence that the provider had taken steps to ensure that the assessed needs of residents were met at night time. For example one resident who required one to one supervision at night had this in place. However, as discussed in Outcome 5 residents' social care needs could not always be accommodated due to the lack of additional staff.

There was a planned roster read by inspectors. However, the rosters did not include the full names of persons, grade and if they were agency or relief staff. One unit's roster did not contain the presence of a second waking night staff even though this was in place. See outcome 18. In addition, the person in charge and management were not included in the roster. Staff did not know who to report to on a daily basis until a manager called the house to inform them.

There were no formal arrangements for one to one staff supervision meetings in the centre. This had been an action at the previous inspection was not addressed.

Inspectors were satisfied a recruitment policy was in place and it was being followed in practice. Personnel files were not reviewed at this inspection however inspectors, had reviewed a number of personnel files at previous inspections. These files will be monitored through future inspections. A service level agreement reviewed at the previous inspection gave assurance of the qualification and vetting of agency staff.

The human resources team showed inspectors records of all staff training completed to date. While the person in charge ensured that all staff in the centre were provided with access to mandatory training including fire safety and protection of vulnerable adults. Records read showed that seven staff had not completed training in the prevention of abuse however a plan was in place to address this. One staff had not completed fire safety training in over one year in line with the service policy of the centre.

Staff had also completed training in movement and handling of residents, however in line with the providers service policy to complete this every three years – six staff had not completed this. Inspectors also reviewed records of staff training in First Aid, CPR, and the safe administration of medication. In addition, some staff had completed training in eating and drinking training, infection control and epilepsy awareness. A number of relief staff worked in the centre and there was evidence of regular training provided to these staff in all mandatory areas.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

Inspectors reviewed this outcome in relation to documentation for residents, policies and staff rosters. There were systems in place to maintain complete and accurate records and the required policies were in place.

Inspectors found there were records required to be maintained for each resident. Inspectors found the documentation, maintenance and accessibility of residents' information required improvements. There were up to four folders per resident, with large volumes of up-to-date and historical information. Therefore it was difficult to identify residents' most pertinent and up-to-date healthcare needs and specific wishes. New documentation was being introduced across the organisation which is anticipated will address this and this work is acknowledged by inspectors. However, further improvement was still required. See Outcome 5.

At the previous inspection all policies and procedures required by the Schedule 5 of the Regulations were reviewed. The provider had ensured the designated centre had all of the written operational policies required. While all policies were in place improvements were identified. For example, there was no infection control policy. The complaints policy did not reflect practice (see Outcome 1). The policy on the prevention of abuse did not fully guide practice (as outlined in Outcome 8).

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:

Anna Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004924
Date of Inspection:	10 and 11 November 2015
Date of response:	09 February 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The privacy of residents personal information was not respected

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

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:

- PIC and named house staff will review all information in each of the homes in this Designated Centre to ensure that any personal information is stored in personal files. The PIC, Provider Visit and Visitation template will include this.
- Folders to be put in place for Eating / Drinking / Swallowing guidelines. These are kept in each kitchen.
- Staff information will be kept in the office and not in communal areas.

Proposed Timescale: 31/03/2016

Theme: Individualised Supports and Care

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

There were no residents meetings held in the centre

2. Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

- The PIC in conjunction with the management team will review the systems and practices in place for each house.
- The purpose of the review is to ensure all systems promote and maximise each persons involvement in exercising choice in their daily life and promote personal independence.
- Resident meetings to involve wider consultation to demonstrate greater choice in house decision making. These meetings will be documented and action focused.

Proposed Timescale: 03/02/2016

Theme: Individualised Supports and Care

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

In relation to complaints there was no evidence of what actions had been taken to address complaints and whether the complainant was satisfied with the response.

3. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

- Policy and procedure will be updated to ensure clear information on the procedure to record and fully investigate each complaint.
- There will be a nominated person who will deal with issues at local/house, manager/PIC and officer level.
- The procedure will include template to document nature of complaint, person responsible for managing complaint, details of investigation, related actions taken, response to complainant, satisfaction level for complainant and if further action required.
- Implementation and communication plan for the updated policy.
- Complaints policy will be amended to reflect local complaints folders in each house.

Proposed Timescale: 31/03/2016

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 outline the additional fees to be charged to residents.

4. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

The memorandum of service provision will be individualised for the residents specific and unique requirements and will include:

- What utilities are to be paid
- Which allied healthcare team / professional are included
- Potential additional charges which could be charged
- This will be led out by the Financial Controller, Management and PIC
- Memorandums to be signed by the PIC and Residents or Representative

Proposed Timescale: 28/02/2016

Theme: Effective Services

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

The contract of care did not clearly outline the services and facilities that are included in the monthly fee.

5. Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the

provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

The memorandum of service provision will be individualised for the residents specific and unique requirements:

- Which allied healthcare team / professional are included
- Potential additional charges which could be charged
- This will be led out by the Financial Controller, Management and PIC
- Memorandums to be signed by the PIC and Residents or Representative

Proposed Timescale: 01/03/2016

Theme: Effective Services

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

The contract of care was not signed by a representative from the organisation.

6. 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:

Memorandums to be signed by the PIC, Residents or Representative

Proposed Timescale: 01/03/2016

Theme: Effective Services

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

The admission policy did not reflect admission practices in the centre.

7. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

- Resident and Next of kin involvement in initial house visit, decoration of room and option to stay overnight.
- Consultation to take place with individuals living in the house.
- Transition plans should reflect policy changes above.

Proposed Timescale: 28/02/2016

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:

There was no evidence of goals being reviewed.

8. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

- The quality department is linking with the PIC in this designated centre to identify those personal plans completed for each resident.
- The information from the Personal Outcome Measures plan will be audited and inputted into the quality database. As part of the audit it will include whether goals have been achieved and how effective was the outcome for the resident.
- The quality department is presently reviewing the Personal Outcome Measures process and plan to ensure that all 23 outcomes which relate to all aspects of the person's life is reflected in the plan and the goals identified for that person and their effectiveness. This will be delivered for 2016 and training attached to same.
- It will commence in this designated centre in January 2016.

Proposed Timescale: 01/06/2016

Theme: Effective Services

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

Residents personal plans were not in an accessible format.

9. Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

- Each person's communication needs is identified
- Keyworkers will commence translating each personal plan in to an accessible format with support from Quality Department, SLT and managers.

Proposed Timescale: 01/05/2016

Theme: Effective Services

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

There was no comprehensive assessment of the health and social care needs for each resident

10. 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:

- Healthcare Plans have been included in the revised personal plans which are being piloted in 3 designated centres. This pilot commenced the 1st of October.
- The SIT (service improvement team) and Quality dept. and relevant healthcare professional have informed the development of Personal care plans which includes a comprehensive assessment of an individual's care needs and from this the development of a plan of care which will guide practice.
- The development of these care plans will be facilitated and signed off by identified healthcare professionals.
- Implementation of Revised Personal Care plans will be in place within this designated centre with the support of the identified planned coordinators.
- The PIC and the planned coordinator for this designated centre will complete the implementation of the healthcare plans.
- These plans will be reviewed at a minimum of 3 months and rewritten every 12 months by the identified house lead.

Proposed Timescale: 01/04/2016

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 layout of the centre did not meet the needs of the residents in terms of respecting their privacy and dignity.

11. 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:

Renovations are currently taking place within the campus to address bathroom privacy

issues and bedroom occupancy within these residential areas.

- The plan for this home is to reduce double and triple occupancy to single bedrooms.
- To create privacy for the shower and bathing areas.
- In the short term rosters within this house will be reviewed and routines relating to personal hygiene and intimate care needs will be based on individual needs assessment and not dictated by the day service schedule.
- Roster review to be completed by the DOS, ADOS and PIC for this designated centre to ensure a routine which is responsive to individual needs.
- Building work has commenced in this centre the estimated time frame for completion will be 3-6 months

Proposed Timescale: 30/06/2016

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 risk management policy was not implemented in practice as there were no systems of identifying and assessing risks within the centre.

12. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

- Each house in this designated centre will have a local Risk register (capturing health / safety / environmental risks).
- Risk policy to be reviewed and implemented.
- Training has commenced with over a 100 staff trained across the organisation with the aim of full implementation by the end of April 2016.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

There was no risk assessment completed on the storage of oxygen in the centre.

13. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

- Risk assessment will be completed and included on risk register and hazard identification.
- Work has commenced on the risk registers in this designated centre. A risk assessment is presently being completed in relation to the storage of oxygen and all other environmental hazards.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

Staff at night are required to leave the centre to assist with fire evacuations in other centres.

14. 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:

- A review of the fire evacuation procedure will be complete by external Fire consultants to review the fire evacuation procedure and level of supports. A meeting took place on 3/2/16 with the Health and safety officer, District Fire Officer, CEO and Night managers. The evacuation procedure was reviewed. The outcome was that the practice of locking the door is discontinued with immediate effect and the night floating staff will be the identified as the "look out" to support peoples safety while staff support the specific area in case of a fire. The evacuation documentation is being revised and updated. The night manager has communicated change in procedure to staff and was also liaising with day managers regarding change in procedure.
- The data on the 3 evacuations completed this year demonstrate that all evacuations were completed in less than 3 minutes.

Proposed Timescale: 28/02/2016

Theme: Effective Services

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

Works relating to fire doors were not completed. There was one area within the two of the centres that required further assessment by the provider with regard to fire containment in the kitchen area.

15. Action Required:

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

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

- Fire doors in all bedrooms indicated will be completed in Designated Centre 1 by end of March 2016.
- An assessment of the kitchen areas will be completed in relation to fire containment.

Proposed Timescale: 31/03/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Some behaviour support plans were not comprehensive enough to guide staff practice.

16. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

The PIC in this designated centre will liaise with keyworkers in each house to review the positive support plans in place and will include on the plan protocols to guide staff. All plans will be discussed and reviewed with the person or their representative and appropriate multidisciplinary team during the personal planning process.

Proposed Timescale: 30/04/2016

Theme: Safe Services

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

Restrictive practices were not reviewed in a timely manner and did not assess the impact on other residents living in the centre.

17. 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 PIC in this designated centre will review the procedure regarding restrictive practices at staff team meetings commencing 30/01/16
- The PIC will review how information is collated at present in relation to restrictive practices and how it will inform the quarterly HIQA report as well as guide practice and learning.
- New Restraints and Restriction Policy (to be signed off) is based on national policy and

evidence and best practice. This policy includes the procedure for reviewing the restrictive practice and its impact on individuals.

•An implementation plan will include briefings and training for staff which will commence Jan 20th 2016

Proposed Timescale: 01/04/2016

Theme: Safe Services

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

Intimate care plans did not guide practice so as to uphold the residents privacy and dignity.

18. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

The PIC in this designated centre will support keyworkers to review individual intimate care plans to ensure they are detailed in a way that guides staff practice relating to respecting dignity and respect.

Proposed Timescale: 31/03/2016

Theme: Safe Services

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

Training records also showed that seven staff had not completed training in the prevention of abuse.

19. 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:

All relevant staff have now attended refresher training.

PIC will monitor staff attendance on a monthly basis using local training records in conjunction with Training Department

Proposed Timescale: 09/02/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

A comprehensive assessment of health care needs and health action plans were not available at the inspection

20. 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:

- Healthcare Plans have been included in the revised personal plans which are being piloted in 3 designated centres. This pilot commenced the 1st of October.
- The SIT (service improvement team) and Quality dept. and relevant healthcare professional have informed the development of Personal care plans which includes a comprehensive assessment of an individual's care needs and from this the development of a plan of care which will guide practice.
- The development of these care plans will be facilitated and signed off by identified healthcare professionals.
- Implementation of Revised Personal Care plans will be in place within this designated centre with the support of the identified Plan Coordinators.
- The PIC and the planned coordinator for this designated centre will complete the implementation of the healthcare plans.
- These plans will be reviewed at a minimum of 3 months and rewritten every 12 months by the identified house lead.

Proposed Timescale: 31/03/2016

Theme: Health and Development

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

Treatment recommended by a speech and language therapist had not been implemented.

21. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

- The PIC/PPIM have reviewed follow up actions following allied healthcare appointments with keyworkers for all individuals to ensure all actions are facilitated and completed.
- New personal plan documentation will facilitate clearer systems of documenting actions and outcomes following appointments for health care

Proposed Timescale: 31/03/2016

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:

Medications were stored in an unlocked container in the fridge

22. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

- Locked container replaced
- Record of daily check commenced

Proposed Timescale: 09/02/2016

Theme: Health and Development

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

Controlled drugs were not recorded as per best practice policies.

23. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

Following meeting with manager and pharmacist updated procedure and practice completed. New procedure in place.

Proposed Timescale: 09/02/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

the following respect:

The statement of purpose did not accurately reflect the staffing levels in the designated centre.

24. Action Required:

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

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

- The statement of purpose will be reviewed. This revision will include information on WTE staffing.

Proposed Timescale: 30/01/2016

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 outline the current number of residents in the centre.

25. Action Required:

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

The statement of purpose has been updated to accurately reflect the number of residents to be registered and the current numbers.

Proposed Timescale: 30/01/2016

Theme: Leadership, Governance and Management

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

Emergency procedures were not outlined in the statement of purpose.

26. Action Required:

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

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

- The statement of purpose will be reviewed. This revision will include information bedroom capacity and emergency procedures.

Proposed Timescale: 30/01/2016

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:

Inspectors found the systems in place to support the person in charge were not adequate.

27. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

- A weekly governance review has commenced which consists of the SIT team representative, Director of Service and CEO to review management cover and to ensure governance as per HIQA requirements. This includes appropriate PIC coverage across all designated areas.
- The Nominated provider is meeting weekly with the PICs to address issues relating to the PIC function and to provide support around action plans.
- The nominated provider has met with this designated centres PIC to identify how they are doing carrying out the role of the PIC and whether additional supports etc. are needed and how this might be provided.

Proposed Timescale: 06/01/2016

Theme: Leadership, Governance and Management

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

The roles and responsibilities of persons involved in the management of the centre were not clear and required clarification.

28. 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:

- A review has commenced (30/11/16) to map out a management model, staff rostering and role profile to be driven by assessed need. The line of accountability (including

roles and responsibilities) from PIC down will be identified in each house in this designated centre.

Proposed Timescale: 01/06/2016

Theme: Leadership, Governance and Management

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

There was no evidence of staff supervision in the designated centre.

29. Action Required:

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

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

- The PICs and PPIM will meet staff on a one to one supervision once a quarter and document.
- There will an identified house lead who will also meet with house staff on a weekly basis around supervision. The CNM 1 will complete supervision with the house lead and the PIC/CNM3 will completed supervision with the PPIM's on a monthly basis.

Proposed Timescale: 30/04/2016

Theme: Leadership, Governance and Management

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

There was no annual review of the safety and quality of care provided to the residents in the centre.

30. Action Required:

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

The Annual Review of Safety and Quality of Care report will be completed by the nominated provider in conjunction with the PIC in this designated centre.

This report will include information collated on the Quality database and key committees within the organisation. The data will relate to key safeguarding and assurance areas these include:

- Risk
- Health and Safety
- Health and Wellbeing

- Complaints
- Personal Plans
- Positive Supports
- Rights / Restrictions / Restraints
- Social / community inclusion

The PIC in conjunction with residents, families and nominated provider reports (unannounced visits) will generate feedback that will inform the report.

Proposed Timescale: 30/01/2016

Theme: Leadership, Governance and Management

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

Unannounced visits to the centre did not detail the actions to be addressed and the persons responsible for completing the actions.

31. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

- Unannounced provider visits reports will be submitted by the end of January 2016 to include an action plan with named actions and persons of responsibility.
- These action plans will be time framed and audits will be carried out by provider nominee or a representative to ensure improvements are carried out and overall learning has taken place.
- The Annual review of safety and Quality of care report will also reflect this learning.

Proposed Timescale: 30/03/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staff rosters did not reflect all staff on duty and highlight persons in management.

32. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

- The Roster will be completed every 2 weeks. The roster will include name, staff grade and hours worked.
- It will identify in red the PIC who is on duty at that time.
- This will be reviewed by the team that is reviewing the staff and manager rosters weekly (as described in Outcome 14).

Proposed Timescale: 01/04/2016

Theme: Responsive Workforce

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

Not all staff had received mandatory training.

33. Action Required:

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

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

- The PIC will identify those staff who need to complete mandatory training in Fire Safety and Prevention of Abuse and schedule this training for the nearest available dates.
- Schedules for mandatory training have been circulated for January and February 2016.

Proposed Timescale: 17/02/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

The finance and prevention of abuse policies required review. There was no infection control policy.

34. 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:

- Infection control policy is now complete and is awaiting sign off by the Board.
- Review completed on Prevention of Abuse Policies clarified that it is compliant with the National Policy on the Safeguarding of vulnerable adults.

•The financial policy has been reviewed and amended and awaiting sign off by the Board as per process.

Proposed Timescale: 30/01/2016

Theme: Use of Information

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

There were major gaps in the documentation of residents personal plans.

35. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

- New revised Personal Plans will consist of one comprehensive plan with a second folder having supporting documentation relevant to that calendar year
- All personal plans will contain information as required under Schedule 3

Proposed Timescale: 20/06/2016