

**Health Information and Quality Authority
Regulation Directorate**

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



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

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 July 2017 08:30	25 July 2017 22:00
30 August 2017 08:50	30 August 2017 18:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 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

Background to the inspection:

An initial inspection in 2014 was completed as a result of the provider submitting an application to register this designated centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, at the time, this centre was not found to be in sufficient compliance with the regulations in order for the Chief Inspector to grant registration. Following this, meetings were held between the provider and the Health Information and Quality Authority (HIQA) and subsequent action plans were agreed. An unannounced inspection took place in November 2015

and improvements were identified, however, a number of issues remained outstanding. Poor managerial oversight and governance arrangements continued to be impacting upon the quality of residents' lives. The complex governance and management arrangements did not identify clear lines of authority and accountability. Subsequently in early 2016, HIQA issued the provider a timeline to implement appropriate arrangements in relation to persons in charge being assigned to centres.

The provider responded by appointing persons in charge to each designated centre. The purpose of this inspection was to inform a registration decision and to ensure the revised governance arrangements were having a positive outcome for residents. Inspectors also followed up on the actions from the previous inspection, to ensure agreed actions were being implemented. This inspection was completed over two days with two inspectors present for the first day and one inspector present on the second day.

How we gathered our evidence:

As part of the inspection, inspectors visited four houses within the designated centre and met with eight residents and six staff members on day one of inspection. On the second day of inspection, the inspector met with 11 residents and seven members of staff. Inspectors viewed documentation such as, care plans, person-centred support plans, recording logs, policies and procedures.

Description of the service:

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

Overall judgment of findings:

Some changes had occurred since the previous inspection, yet, inspectors found that significant progress was not evident in order to bring about compliance with the regulations and improve residents' experience of living in the centre.

This inspection report identified 36 actions in need of address, resulting in four outcomes being evidenced as majorly non-compliant:

Outcome 5: Social Care Needs

Outcome 12: Medication Management

Outcome 14: Governance and Management

Outcome 17: Workforce

These areas required significant improvement to ensure that effective systems were implemented in medication management and the monitoring of the quality and safety of the care provided in the centre. Alterations to the workforce system were also required as the numbers of staff were not based on the assessed needs of residents.

Out of the remaining 14 outcomes inspected against, six were found to be in moderate non-compliance, four were substantially compliant and four were compliant.

The person in charge facilitated the inspection along with a clinical nurse manager.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Residents were consulted and participated in decisions about the organisation of the centre. However, significant improvements were required in relation to the privacy and dignity of residents.

Inspectors found improvements were required in relation to respecting the privacy and dignity of each resident in relation to their living space. During the first day of the inspection, other staff members from various locations on campus were in and out of the houses throughout the day. On one occasion the door bell was used, on all other occasions staff members walked in through the house and proceeded with the purpose of their visit. On the second day of inspection significant improvements were observed in relation to this, as staff members rang the door bell before entering.

In relation to personal communication, inspectors identified some personal information was displayed in a public place within the bathroom of one house. Inspectors also observed one resident was not appropriately dressed in the afternoon in order to protect their dignity on the first day of the inspection. This was brought to the attention of staff members on the day.

On the second day of inspection, the inspector observed routines and practices did not promote residents' independence or choice and in some instance staff members were not familiar with residents' individual preferences. The inspector observed two residents were asleep in their bed, yet, their bedroom door was open. During this time both houses were noisy and several staff members were walking up and down the hallway talking to other residents and assisting residents to get up. The inspector asked if it was

resident's choice to sleep with their door open, however, this information was not available. In one house the inspector was informed all bedroom doors were open when they started work in the morning. The inspector also became aware that nightly checks were completed, some of these were hourly. In some instances the inspector was informed residents' bedroom doors were left open to facilitate this practice. In another house, doors were closed and staff members would open the doors to check on residents. The rationale for this practice was not evidenced based from the healthcare needs of residents.

During the previous inspection sharing of bedrooms was identified as an issue. This has been addressed and inspectors found each resident had their own bedroom. Residents spoken with were satisfied with this and some residents showed inspectors their bedrooms. The bedrooms were decorated in accordance with residents' personal preferences. Some residents spoken with identified they would like to have locked storage to store personal items such as, jewellery within their bedrooms.

During the first day of this inspection, inspectors were in one house at a meeting with the person in charge and a clinical nurse manager. Following this meeting the house was empty with no residents or staff members present. Inspectors waited for a staff member to return, as inspectors were not satisfied with the security measures in place within the house. The staff member spoken with ensured appropriate action was taken within the house.

On viewing one resident's finances, the inspector identified a resident paid for a medical procedure and car parking while attending their hospital appointment. The inspector requested to view evidence of the consultation which took place to result in this practice; however, this was not available.

On the first day of the inspection, inspectors identified improvements in relation to the documentation of complaints; however, the follow up to some of these remained unclear in relation to transport for one resident and collecting meals. It was also unclear what measures were put in place for improvement in response to some complaints.

Inspectors viewed minutes of residents' meetings and discussed these with some residents. This was an improvement as residents were not consulted in relation to aspects of the centre at the previous inspection

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

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

Findings:

There were systems in place to assess residents' communication needs and to provide supportive interventions as required. However, some of these were not maintained up-to-date on the day of inspection.

Visual schedules were maintained for various aspects of the centre in relation to meal planning and staff rotas. However, this visual rota was not reflective of the staff members working in the centre during both days of inspection.

Individual communication requirements were highlighted within each resident's personal plan. The communication section provided key information on supporting the resident to communicate.

Communication passports were in place, these provided additional information on residents' communication needs as required. The communication passports were developed with speech and language input and outlined how the resident communicates and provided a communication dictionary and a guide on the specific communication supports required by the resident.

Residents' communication needs were identified in their communication assessments. From a sample number of four files viewed in relation to communication, inspectors found the assessments captured the individual communication requirements of each resident.

Inspectors also found residents had adequate access to the radio, television, newspapers and phones in the centre.

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:

Residents were supported to develop and maintain personal relationships with family

members. However, links with the wider community were limited.

Inspectors spoke with staff members, residents and one family member. These individuals identified community trips and visits were mainly facilitated by day services or family members.

Inspectors acknowledged one resident attended a community-based activity outside the centre on a weekly bases and this resident discussed this with one inspector.

Family members were also encouraged to get involved in the lives of residents in accordance with residents' preferences. Family members could and did visit the designated centre on a regular basis and were free to do so. Residents had pictures of family members in the centre.

One inspector met with one family member who visits weekly and takes their family member out of the centre into the community.

There was also a policy in place which outlined that visitors were welcome in the centre.

Judgment:

Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

The centre had a policy on admission which outlined the arrangements in place for admitting new residents to the centre; this was currently awaiting board approval.

Inspectors viewed a sample of four contracts of care and found that each resident had a contract of care in place. However, the contracts did not outline the services to be provided and all of the fees to be charged. The provider identified during the feedback session that the organisation was currently in the process of reviewing the contracts of care.

Judgment:

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 identified that residents did not have the opportunity to participate in meaningful activities that were appropriate to their interests and preferences. In addition, staff members were not guided effectively as some residents did not have up-to-date personal plans in place.

Inspectors requested to view two specific residents' personal plans, however, these were not available. Inspectors were informed these residents did not have personal plans as they were under the palliative care team. Inspectors requested evidence where the decision was made for these residents to no longer have a personal plan outlining social goals and activities. This information was not available. One inspector spoke with one of these residents who identified they were attending a day service as they liked going there.

Out of a sample of six personal plans viewed over the two days, one resident had social goals set for 2017, however, none of these were related to the designated centre. Goals set included, dog therapy in the day service, bus trips in the day service and referral to occupational therapy. Inspectors found some goals were dated 2014 and 2015 with no level of effectiveness in some of the plans viewed. The reviews and follow-up process was also unclear for example, one resident's goal was for the resident to vote. The reason documented for not achieving this goal was due to "lack of documents". No goals were documented for 2016 or 2017 or what progress was made in sourcing the required documents. Members of staff spoken with were unable to identify any progress in this area.

Inspectors viewed documentation and found one resident did not participate in any activities in the evening over a 6 week period. One inspector spoke with a staff member to ascertain if the documentation was accurate or if there was a reason why the resident was not engaging in activities during the evening. Inspectors were informed residents

did not participate in activities during the evening in the centre. Staff members identified activities were facilitated by centre-based staff at weekends only if sufficient staff members were available.

Inspectors observed that residents in three of the four houses were not engaged in any meaningful activities. As these residents were seated in chairs within houses with no apparent stimulation for significant periods of time other than meal times.

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):

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

Findings:

The location, design and layout of the centre was suitable and met residents' individual and collective needs in a comfortable way.

The centre comprised of four houses, all of which were located in a campus setting. Each resident had their own private bedroom, and these rooms were decorated to their individual taste. There were separate kitchens with adequate cooking facilities and adequate communal space available in all houses.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

There were systems in place to promote the health and safety of residents, visitors and members of staff. However, areas were identified in relation to risk management and fire management during this inspection.

There were systems in place for the prevention and management of fires. Certificates and documents were present to show fire alarms, emergency lighting and fire equipment were serviced by an external company as required by regulations. However, in two of the four houses the fire equipment was overdue a service since May 2017. This was rectified by the second day of inspection. The procedures to be followed in the event of a fire were displayed in a prominent place. Regular fire drills were taking place in the centre. On the first day of inspection some staff members spoken with during the morning period were unclear of the fire procedure to be followed within one house. Some members of staff had not received an induction in relation to the fire procedure from a house specific perspective.

Some staff members were unable to identify where the fire exits were and what routes to take when given scenarios from inspectors. These staff members were also unable to identify what supports residents required in the event of a fire. These staff members identified they would take direction from the nurse, present in the house who was familiar with the procedure to be followed. In addition some residents' plans did not guide staff members in relation to what supports were required or what additional supports were required following fire drills. This included the use of a wheelchair during night time evacuations as an example. During the second day of inspection, the inspector viewed the safety plan for this resident and the document had been updated, however, this did not include the use of a wheelchair for night time evacuations.

The centre had a policy on the management of risk. The centre maintained a risk register which outlined risks in the centre and the controls in place to manage the risks. Risks included medication, falls, fire and chemicals. There were individual risk assessments for residents in place, these included epilepsy, falls and choking. Inspectors found the follow up and the actions implemented for individuals identified as high risk as inconsistent within the centre. Some staff members spoken with were unclear of what individual risks were despite these staff members working with residents on the day of inspection. Inspectors found this was not ensuring safe and consistent delivery of care. During the morning, in one house staff members were reliant on guidance from one staff nurse in relation to all aspects of care delivery. This staff nurse was also responsible for administering medication and supervising breakfast during the morning period.

The centre had infection prevention, and control procedures in place. Inspectors observed personal protective equipment and hand hygiene facilities were available in the centre. System in place for clinical waste required attention to ensure procedures were consistent with infection prevention and control procedures for the disposal of waste. Inspectors observed clinical waste bags were being used for domestic waste. Inspectors also observed one container for the disposal of sharps had no label or tagging system used for identification purposes.

The centre had an up-to-date health and safety statement in place. This outlined the responsibilities of the various staff members within the organisation.

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):

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

Findings:

There were appropriate measures in place to protect residents from being harmed and to keep people safe. Improvements were required in relation to chemical and environmental restrictions and staff members' knowledge in relation to the reporting structure within the centre.

Inspectors found intimate care support plans were in place; however, these were not guiding practice and did not contain sufficient detail to guide staff members in relation to maintaining the dignity of each resident.

Guidance for staff in relation to behaviours that challenge could not be found on the day of inspection for one resident.

Inspectors viewed a positive behaviour support plan dated 2009 for another resident. Inspectors asked staff members present in the house if this was the document implemented. Inspectors were informed that if the document was in the file it was to be used. However, another member of staff identified a communication modification and behaviour plan dated 2017 was also available and the 2009 document was no longer current. Inspectors found the system unclear as it did not guide staff consistently. Some staff members present were unclear of what guidance documents they were to implement should the need arise.

Restrictive procedures including chemical and environmental restraint were used; however, some of these were not used in accordance with evidence based-practice. One resident was prescribed a PRN (a medicine only taken as the need arises) medicine to alter their behaviour. This medication was to be administered for severe agitation when

de-escalation fails, yet, there was no plan in place for staff members to follow or how to recognise when the resident was experiencing this. Staff members spoken with provided inconsistent information in relation to what indicators would identify when the resident would require this intervention. On the second day of inspection, the inspector viewed the resident's daily notes for when this medication was administered. However, this did not identify why the medication was administered, nor was the staff member guided by the plans in place for the resident.

Inspectors acknowledged the reduction in the level of physical restrictions in place for one resident, as measures had been taken to implement the least restrictive intervention for this resident. However, improvements were required in relation to some environmental restrictions. These were not reviewed at regular intervals, for example, one assessment in place was dated 2015. This identified the rationale for the use of the restriction.

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

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:

A record of all incidents occurring in the designated centre was maintained and where required, notified to the Chief Inspector. The person in charge was aware of the legal requirement to notify 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:

Inspectors identified residents had very limited opportunities for new experiences and social participation.

Social activities were provided by day services with very limited social activities facilitated by the designated centre.

Residents attended day services and one resident had a day service facilitated from the centre. During the course of the inspection, residents spoke with inspectors about their day service.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Inspectors identified significant improvements were required to ensure residents assessed healthcare needs were met.

The healthcare needs of residents were completed via a plan incorporating nine areas of assessments. These included communication, breathing and circulation, nutrition and hydration, continence and elimination, personal care, meaningful activities and sleep and rest. Inspectors viewed six healthcare plans and found some of these required improvement to ensure medical treatments recommended for residents were implemented and healthcare needs were met. Areas identified included:

- assessments in place were not followed up on, for example, a resident assessed as a high risk in relation to their skin integrity has an assessment dated 26 September 2016.

Inspectors asked what interventions had been implemented; however, no follow up was evident for the resident. Other assessments viewed in relation to nutrition, contained inconsistent information. Inspectors found these documents were not directing care to meet the assessed needs of residents. Staff members were also not guided effectively to ensure some residents received the required healthcare provisions

- the management of healthcare conditions such as, diabetes mellitus were not accurately outlined in residents' plans in relation to blood glucose monitoring. Inspectors viewed evidence of these interventions; however, staff informed inspectors these interventions were not accurate and were not taking place as documented in the plan. Inspectors viewed another resident's plan; however, no interventions were in place despite the resident having a diagnosis of diabetes mellitus. Inspectors found some residents healthcare treatment was not implemented as recommended

- interventions outlined in one treatment plan for hypertension were not being consistently recorded and there was no appropriate guide in place for staff indicating when medical treatment should be sought. Inspectors found that one recording had been brought to the attention of the resident's GP (general practitioner), who had recommended a specific monitoring regime. Yet, this had not been fully implemented as there were gaps in the monitoring records viewed. This was brought to the attention of the person in charge by inspectors on the first day of the inspection, as staff members could not confirm whether the resident had been reviewed by the GP. However, on the second day of inspection staff members identified the resident had not been seen by the GP. The inspector instructed this resident to receive medical attention. In the afternoon the person in charge identified this resident had been seen by a GP previously and was awaiting a medical assessment. The person in charge identified they would ensure clear information was provided to staff members in relation what care was to be provided to the resident as records maintained did not clearly direct care. This lack of appropriate healthcare provision was not ensuring healthcare needs were effectively monitored to ensure residents received care in accordance with their diagnosis

- inspectors viewed a pain assessment in place for one resident, this resident spoke with one inspector. This resident was clearly able to identify when they were in pain and staff members also confirmed this. Inspectors asked staff members why this was in place for the resident, however, staff members were unclear. Therefore, inspectors found practices relating to this aspect of care provision was based on routine instead of the assessed need of the resident

- one epilepsy management plan viewed was dated April 2015, with no evidence of review to ensure the resident's healthcare treatment was suitable to meet the current needs of the resident

- advanced care directives were in place for three residents. Some improvements were required as the end-of-life assessments were blank, with advanced care directives in place since 2015. The resident had been reviewed regularly by a clinical nurse specialist. Staff members spoken with were unclear what the process was for this. Therefore, some members of staff were not clearly directed in this aspect of care provision

- the review process in place for areas of need required improvement to identify the

effectiveness of the interventions implemented to ensure these were having a positive impact on residents' healthcare needs.

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

Any resident requiring modification to the texture of their food had this information outlined in the residents' files. Inspectors viewed feeding, eating, drinking and swallowing (FEDS) assessments in place for some residents.

Regarding food and nutrition, inspectors found residents participating in mealtimes within the designated centre in accordance with residents' preferences in relation to food choices.

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):

No actions were required from the previous inspection.

Findings:

Medication management within the centre required significant improvement to ensure suitable practices relating to the storing, disposal and administration of medication.

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

There was no system in place in relation to the use of rescue medication. Inspectors asked staff members if they would take this medication out with them, if the specific resident was leaving the centre with staff. Inspectors were informed staff members would have to use their own judgment, for example, if a nurse was taking the resident out they would bring the medication. Inspectors requested to view the records of the rescue medication leaving the centre, however, staff members identified no record was maintained. Inspectors were informed that if a non-nursing member of staff was taking the resident out they would either call an ambulance or come back to the centre. The staff themselves would have to decide, as no guidance was available. Inspectors found this practice was not ensuring consistent care provision in relation to the management of rescue medication.

On the day of inspection, one inspector identified one box of medication was out of date. The inspector was informed this was to be returned to the pharmacy. However, the inspector also observed this was also highlighted within an audit dated 31 March 2017, no action had occurred since the audit.

Daily counting had commenced for barbiturates within one house, however, inspectors were informed of two different responses for this practice. One response was that the house had too much stock at the end of the month and another member of staff identified there was too little stock at the end of the month. Inspectors requested clarity in relation to this and was provided with an incident form located off site from the house. This incident risk form identified 18 tablets were unaccounted for and daily counting maybe required, this was dated 31 May 2017. The counting of this medication commenced on the 04 June and stopped on the 25 June 2017. Inspectors were informed that counting should have continued; however, due to lack of regular staff members, this had been missed. No outcome to this issue was made available to inspectors.

On entering one house, one inspector observed the medication press was open and unattended. The inspector brought this to the attention of a member of staff, who immediately locked the press. Within another house medication for one resident was not within the medication press, this was later found within a documentation press.

Inspectors found some guidance documents in relation to PRN medicine was out of date and medicine no longer prescribed for the resident as a PRN was specified in the guidance. This was further compounded by the fact some PRN medicine was shared by residents, therefore, increasing the risk of medication errors with inaccurate guidance documents.

Inspectors found some creams did not have a date of opening and some did not contain the resident's name.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. However, inspectors found this policy was not always adhered to within the designated centre.

Medication was supplied to the designated centre from the organisation's based pharmacy and medication was recorded when received.

There was a system in place for recording, reporting errors and reviewing medication. Inspectors viewed incidents which occurred within the designated centre; however, there was no evidence of learning from some of these incidents to mitigate the risk of future reoccurrences.

Inspectors found the signature bank within the designated centre was completed.

Judgment:
Non Compliant - Major

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

Findings:
The details contained within the statement of purpose in relation to the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 was not reflective of practice within the centre. Areas included:

- facilities within designated centre
- the specific care and support needs within designated centre
- arrangements for residents to engage in social activities, hobbies and leisure interests
- arrangements for residents to access education, training and employment
- staffing.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

implemented.

Findings:

Considerable improvements were required in oversight of this centre to ensure safe, consistent and effective delivery of care in accordance with residents' needs. This was evident through the findings of this inspection within the outcomes inspected and the level of non-compliances identified.

Inspectors found the management structure in place did not have clear lines of authority and accountability among the layers of management within the designated centre. Inspectors acknowledged the person in charge had resigned their post and another staff member had been appointed. However, on the first day on inspection, the person in charge of another centre was providing the managerial operational oversight to this centre. Inspectors sought clarity on a number of occasions and were informed the person in charge for the other centre would not have input into this centre when the newly appointed person in charge of this centre was on the rota. On the second day of inspection, the inspector observed no change had occurred in this area. For example, staff members identified they would seek support from managers in other designated centres.

Throughout the first day, inspectors observed the person in charge from the other centre spending a considerable amount of time within this centre. For example, completing an induction with an agency staff member in one house for over 45 minutes and organising staffing in another house. Inspectors were unclear why this practice was occurring when two other clinical nurse managers were present in the centre in addition to the newly appointed person in charge. Overall, inspectors identified that, roles were not clearly defined nor were staff members aware of the scope of various managers.

For this centre the person in charge was supernumerary to the rota and was supported by two clinical nurse one managers whom were also supernumerary. Both the person in charge and the clinical nurse managers reported to a clinical nurse manager three who was also supernumerary.

Inspectors viewed minutes of staff meetings within the designated centre, however, these were not conducted regularly and were completed within each house. No staff meetings took place from a centre-based perspective despite staff moving from house to house. There was no evidence of areas requiring follow up by the management team being discussed. This was evident in several areas in relation to residents needs, falls management and staffing levels. Inspectors were unable to view any meetings taking place between members of management of this centre to ensure effective governance, operational management and administration of the centre was implemented. Inspectors were also unable to view any evidence where the service provided in the centre was discussed in terms of residents safety and residents' needs to ensure all members of staff were implementing care in a consistent approach. Instead, limited individual meetings were held with various day services in relation to residents' needs. The inspector acknowledged this collaboration; however, relevant information was not subsequently recorded in residents' files.

Inspectors viewed limited audits in relation to hand hygiene and medication, however,

the quality of service delivered to residents in relation to health and social care was not audited from a centre's perspective.

Effective arrangements to support, develop and performance manage all members of the workforce was not occurring within the centre. The centre had a yearly performance appraisal system in place, but this was not being implemented effectively. The inspector viewed a sample of five staff members' performance appraisals. Two of these staff members records viewed had one completed in 2017, one staff member's records identified the previous appraisal was completed in 2013. The inspector identified this did not facilitate staff members to exercise their personal and professional responsibility for the quality and safety of service they provided within the centre.

The provider had carried out an unannounced visit on a six monthly-basis in 2016 to the four houses in this centre and one in 2017. An action plan was developed with timeframes and people to carry out these actions however, some of these actions remained ongoing since March,

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 person in charge had resigned from their post and the provider had appointed the head of Cheeverstown centre and community transitions as the new person in charge. The provider identified this was a temporary measure on the first day of inspection and the recruitment of an individual to take up this role was under way. On the second day of inspection the provider had recruited a person who was due to commence the following week.

The required paper work was being processed by the provider at the time of 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:

The centre was resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose.

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:

The centre did not always have sufficient staff numbers with the right skill-mix, qualifications and experience to meet the assessed needs of the residents. The rotas viewed were also not reflective of practice.

Overall, inspectors found significant improvements were required to ensure continuity of care to residents and ensure negative outcomes for residents were not occurring due to lack of regular familiar staff members. Inspectors viewed the proposed and actual staff rota and significant gaps were present. The centre was heavily reliant on relief and agency staff members. Inspectors viewed several days where only one regular staff nurse was present and in some instances none were present. This was evident during both days of inspection, for example, within one house no regular staff members were present. Instead the staffing consisted of an agency nurse and a member of staff from the relief panel.

From speaking with staff and viewing the rota, the designated centre was operating as two designated centres, consisting of two houses each. For example, staff members were not aware of what staff members were on outside of the two houses on the rota. The rota in each house did not include the whole designated centre. Inspectors found that staff resources were not organised in a way to meet the assessed needs of residents. For example, on the first day of inspection the staffing numbers on the morning of the inspection were more than what inspectors were informed was required. However, the following day the rota identified staff vacancies. Inspectors requested to view the assessment of needs from a staffing perspective within the centre; however, this was not completed. The newly appointed person in charge had a plan in place to complete this for each house within the designated centre.

In another house, one staff member was not aware of their rota, this resulted in a staff member coming in on shift late. From speaking with the staff member they informed inspectors their rota had been changed and they were not made aware of this change. The centre had commenced a new roster system, which involved the rota being completed by staff outside the designated centre following a monthly meeting with the person in charge. In one house staff members spoken with did not know who the manager was for the centre on the first day of inspection, therefore, they rang the manager's office to find out. Inspectors asked to view the manager's rota in the house; however, this was not the current rota available for staff members.

On the second day of inspection, the inspector became aware that another member of staff was present in one of the houses during the night for periods. This member of staff was not reflected on the rota in the house.

The inspector identified that no supervision was taking place, for example, a record was maintained, however, this had nine entries relating to five staff members. This book viewed contained a record of conversations including telephone conversations. The inspector highlighted this to the person in charge, as this practice was not ensuring staff members were supervised. Staff members spoken with identified they did not receive supervision. Members of staff identified this would only occur if an incident happened.

From viewing 30 staff members' training records, refresher training was required by five staff in the area of people moving and handling, nine staff members required training in behaviour de escalation techniques and three staff members required training in the area of fire safety.

One inspector reviewed a sample of staff files for the organisation on a separate day to the inspection and found that the files contained all the information required by Schedule 2 of the Regulations.

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):

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

Findings:

Improvements had occurred in relation to records and documents since the previous inspection.

Schedule 5 policies for the centre had been submitted into HIQA before this inspection. The staff training and development policy was in draft format dated 2017 and the admissions policy was awaiting board approval.

Overall, inspectors found the retrieval of some schedule 3 documents was difficult, and in some instances, documents were unavailable, out of date or blank within residents files. Information relating to residents' needs was recorded in various books not individualised to each resident.

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:

Karina O'Sullivan

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004927
Date of Inspection:	25 July 2017 & 30 August 2017
Date of response:	26 September 2017

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:

Evidence that each resident participated in and consented, with supports where necessary, to decisions about his or her care and support in relation to funding medical procedures and car parking fees were not available within the centre.

1. Action Required:

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

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

The costs incurred by a resident for a medical procedure (Dexa Scan) will be addressed by the PIC with the resident's family members. A record of the consultative process and agreement reached will be kept in the resident's personal file in the financial section along with a record of any monies refunded to the resident.

-Cheeverstown will reimburse car parking costs to the resident's account

-All consultation and discussions with residents and their families in relation to funding of medical procedures and any payments made from residents own funds will be clearly documented in the resident's plan of care under Financial. This will be completed by the nominated house CNM1 or the staff assigned to support the resident.

Proposed Timescale: 21/10/2017

Theme: Individualised Supports and Care

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

Inspectors identified that each resident's privacy and dignity was not respected at all times in relation to their personal space, houses, personal communication and personal care.

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

2. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

-Each house will be respected as the home. Staff will ring the doorbell before entering. The manager or identified lead staff on shift will be responsible to highlight staff not compliant showing this respect so that this can then be followed up with individual staff members under performance management.

-Personal information for individual residents has been removed from the bathroom.

-Each resident's personal plan will be reviewed with them by the nominated CNM1 to the house and/or key worker to ensure all their individual healthcare and social care

needs are assessed and the appropriate level of support is given.

-Practices such as night-time checks or doors open at night will cease unless there is an individual plan of support required specific to a resident's needs. An appropriate plan to meet the resident's individual need will be clearly documented in the resident's care plan and a risk assessment complete. The PIC will be responsible to ensure this is completed. The PIC will hold staff on duty in houses accountable for the practice within the house.

-The PIC will arrange for night duty managers will be responsible to complete a weekly audit to ensure that 'night-time checks' or doors open only happen if there is an individual assessed need which is clearly documented and feedback to PIC for action.

Proposed Timescale: 21/10/2017

Theme: Individualised Supports and Care

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

Some records of complaints viewed were unclear in relation to the outcome and what measures were required for improvement in response to a complaint and if these were implemented.

3. Action Required:

Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

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

-The outcome to the resident's original complaint (as identified on the 1st day of inspection) will be recorded on the Complaint Log.

The resident will be given feedback and this will be documented. The resident in DC4 is now supported to collect her pension weekly. This action will be completed by the PIC.

-The Centre's Complaints Log will be reviewed and any remaining outstanding issues will be addressed. Any resolution or feedback discussions on complaints will be recorded. If there are complaints that are unresolved, the PIC will meet with the resident again to address the complaint and feedback.

Proposed Timescale: 21/10/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Aids and appliances were used within the centre such as, visual roster, however, these

were not reflective of practice on the day of inspection.

4. Action Required:

Under Regulation 10 (3) (c) you are required to: Ensure that where required residents are supported to use assistive technology and aids and appliances.

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

-Updating the visual roster at the start of each shift is the responsibility of the lead staff in the house. It will be completed as part of the 'Safety Pause'.

-Photographs of regular staff and core support staff will be readily available in each house. This is the responsibility of the assigned CNM to the house.

-Other support staff will be supplied with their photograph for the visual roster and they will carry it on their person with their staff ID. It is the responsibility of staff assigned to houses to ensure that they place on the visual roster. The Support Team Co-ordinator is responsible to ensure his team are compliant with this and will audit the houses in DC4 weekly, and address non-compliance with this requirement with staff under performance management.

Proposed Timescale: 21/10/2017

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

Theme: Individualised Supports and Care

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

Supports to develop and maintain links with the wider community in accordance with residents' wishes were limited.

5. Action Required:

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

-Consultation will take place on a weekly basis with residents in relation to social outcomes and planning activities in the home and in the community. This plan will be recorded by house staff in the house meeting book. Responsibility for this is assigned to the CNM1 or an identified staff member weekly.

-A weekly activity log for each resident will be kept by assigned residential and day service staff. This plan will be discussed with the manager / PIC weekly.

-Residents will be supported to attend activities of their choice in the community.

-Fortnightly, day service and residential managers will meet to explore further

community engagement opportunities and how to meet resident's wishes.

Proposed Timescale: 21/10/2017

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:

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

6. 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 Care for the residents living in the Centre is currently being revised to reflect the current fees and any additional charges. This is with Cheeverstown Board the week of 26th September for discussion and approval.

-Residents will each have their individual RSSMAC assessment following approval of the Memorandum of Care and the fee to be assigned

-Each person and their family representative will then have individual communication on how this applies to them (what is covered by the fee, and what is not covered)

Proposed Timescale: 30/11/2017

Outcome 05: Social Care Needs

Theme: Effective Services

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

Evidence that arrangements were in place to meet the assessed needs of each resident from a social perspective was not evident.

7. 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:

-Each resident's social care plan will be reviewed with them by the nominated CNM1 to

the house and/or key worker to ensure all their individual social care needs are assessed and the appropriate level of support is given. Meaningful activities specific to the individual will be identified. A plan will be put in place

-Residents on a Palliative care plan will be prioritised to have their social care needs assessed and supported.

-Consultation will take place on a weekly basis with residents in relation to social outcomes and planning activities in the home and in the community. This plan will be recorded by house staff in the house meeting book

-A weekly activity sheet for each resident will be recorded by the keyworker and audited weekly by the manager assigned to the house.

Proposed Timescale: 21/10/2017

Theme: Effective Services

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

Some residents' personal plans viewed were not reviewed annually or more frequently if there was a change in needs or circumstances.

8. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

-The personal plans of residents in each house will be reviewed (at least annually) and updated in accordance with the resident's current needs. The CNM assigned to the house will be accountable for this review and update.

Proposed Timescale: 21/10/2017

Theme: Effective Services

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

Personal plan reviews did not assess the effectiveness of each plan and take into account changes in circumstances and new developments.

9. Action Required:

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

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

-The personal plans of residents in each house will be evaluated and updated in accordance with the resident's current needs. The CNM assigned to the house will be responsible for this review and update.

The personal plans of residents will guide staff in their daily practice and their support of residents. If a staff is unfamiliar with the current needs of the resident, the CNM or lead staff in the house will direct the staff member to the personal plan before they support the resident

Proposed Timescale: 21/10/2017

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 system in place in the designated centre for the assessment, management and ongoing review of risk, required attention to ensure practice reflected the assessments in place. Some staff members were not aware of what the potential risks were within the centre.

10. 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:

-All individual risks for residents will be identified on their Individual Safety Plan. The CNM or lead staff in the house is responsible to ensure that all staff providing support to an individual are familiar with this plan and the risks identified. Each staff is also responsible to read this plan before supporting an individual.

-The Safety Pause has been introduced at the start of shift changes. This identifies the risks of concern to the individuals living in the house. It focuses staff to Fire Evacuation Plans, Feeding Eating Drinking Swallowing (FEDS) Guidelines and other risks particular to residents in the house. It is the responsibility of the CNM or lead staff in the house to lead out on the Safety Pause.

-The risk register for the house and Designated Centre will be discussed with staff at each staff meeting as an ongoing agenda item. Staff meetings in houses will be held fortnightly and minutes will be available in the house for all staff to read. On reading the minutes, staff will sign to indicate they have read the minutes of the meeting.

Proposed Timescale: 07/10/2017

Theme: Effective Services

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

Systems in place for clinical waste required attention to ensure procedures were consistent with infection prevention and control procedures.

One container for sharps had no label or tagging system for identification purposes.

11. 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:

-All sharps containers in the Designated Centre will be identifiable. An Infection Control Audit will be completed in the Centre, to ensure proper control measures are in place. This will be completed by nursing and household management.

-All actions identified will be addressed to ensure the correct infection control procedures are in place.

Proposed Timescale: 21/10/2017

Theme: Effective Services

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

Some plans viewed did not guide staff members in relation to the evacuation procedure for individuals including additional aids.

12. 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:

-New Personal Emergency Evacuation Plans per resident will be put in place. These plans will identify the procedure for evacuating residents from their home and identify the nearest Assembly Point.

Proposed Timescale: 21/10/2017

Theme: Effective Services

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

Some staff members spoken with were not aware of escape routes and arrangements

for the evacuation of residents within the house they were working in.

13. Action Required:

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

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

-All staff working in the Designated Centre will be up-to-date with mandatory fire training. 1 staff member has completed training on the 11th September. 2 other staff are booking for training within the next 4 weeks.

-Fire evacuation drill procedure particular to the individuals living in the house are included at the start of each shift change in 'The Safety Pause'.

-There will be weekly simulated fire drills and in DC 4 for the next 4 weeks to address the knowledge deficit of staff. These are additional drills to the planned fire drills for the Centre.

Proposed Timescale: 07/10/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Staff did not have up to date knowledge, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. No guidance was available in one instance and in another the guidance was not detailed enough to ensure consistent delivery.

14. Action Required:

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

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

-Positive Behavioural Support Plans will be reviewed in conjunction with the multidisciplinary team. The care plan will be revised to guide staff on measures to take to manage behaviours and de-escalate a situation. The plan will also guide staff to recognise an escalation in behaviours and the appropriate intervention to take. All proactive and reactive strategies will be documented by the staff providing support to the individual.

-A 'prn protocol' will be developed and staff will use this to give them a direction of when to intervene and what intervention to use, this will give guidance to ensure a

consistence approach to care delivery.

-Staff are scheduled for MAPA training on December 7th 2017

Proposed Timescale: 21/10/2017

Theme: Safe Services

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

Some chemical and environmental restrictions used, they not applied in accordance to evidence based practice.

15. Action Required:

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

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

-There will be a review of environmental restraints used in each house. If the restraint is required and evidence based, the documentation and reasoning behind the restraint in use will be clearly evident in the individuals care plan. The PIC is responsible for completion of this action.

-There will be a review of chemical restraints used in each house. If the restraint is required and evidence based, the documentation and reasoning behind the restraint in use will be clearly evident in the individuals care plan. The PIC is responsible for completion of this action.

Proposed Timescale: 21/10/2017

Theme: Safe Services

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

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

16. Action Required:

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

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

-Intimate care plans will be reviewed and updated as necessary to ensure the resident's dignity and bodily integrity is respected. Managers assigned to houses within the

designated centre will be responsible to ensure these are updated. CNM1s will report to the PIC on this.

-When providing personal intimate care to residents, staff will do so in line with the residents wishes and preferences as outlined in their personal plan.

-Staff failing to follow the personal plan of individual residents will be managed under Performance Management.

-There will be increased presence of managers in houses supervising practice and mentoring staff.

Proposed Timescale: 07/10/2017

Theme: Safe Services

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

Some staff members were unclear of the reporting structure within the centre.

One staff member was unclear on what constituted abuse.

17. 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 reporting structure within the Designated Centre is outlined to staff and will be evident in each house.

-All staff within the Designated Centre will be up to date in terms of Safeguarding Training. 3 staff are booked on to training in October

-The PIC and CNM1s will also discuss safeguarding with staff on a daily basis to ensure that they understand the training and how it applies to their daily support of residents.

-The PIC and management team will promote an open culture of reporting. The PIC will organise a local safeguarding workshop with social work colleagues to be delivered to staff at house level. The Support Team Coordinator will organise a workshop for the Support Team

Proposed Timescale: 21/10/2017

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Limited opportunities for education and training in relation to social activities was evident within the centre for residents.

18. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

-Residential staff will work in partnership with day service staff to meet the social care needs of residents and access opportunities for education, training and employment in line with the individuals own goals.

-Each resident's social care plan will be reviewed with them by the nominated CNM1 to the house and/or key worker to ensure all their individual social care needs are assessed and the appropriate level of support is given.

-A weekly activity log for each resident will be recorded by the keyworker and audited weekly by the manager assigned to the house.

Proposed Timescale: 28/10/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Appropriate healthcare for each resident, having regard to each resident's personal plan was not provided as identified within the main body of this report.

19. 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 PIC will ensure each resident's assessment in relation to healthcare needs is reviewed and current. Documentation will be reviewed by the nominated CNM to the house and/or keyworker. The plans will guide staff to ensure resident's healthcare needs are met. Treatment will be implemented as recommended and staff will ensure there is medical or multidisciplinary follow up where indicated.

-All appropriate medical and nursing care and support as outlined for residents will be addressed.

-The CNM assigned to the house will supervise staff practice and address any failings in

the provision of appropriate healthcare for a resident.

-Individual staff will be held accountability for failure to provide support against assessed healthcare needs.

Proposed Timescale: 21/10/2017

Theme: Health and Development

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

Some medical treatment recommended for residents was not facilitated.

20. 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 medical treatment recommended for residents will be facilitated.

-The PIC will ensure each resident's assessment in relation to healthcare needs is reviewed and current.

-Documentation will be reviewed weekly by the nominated CNM to the house and/or keyworker. The plans will guide staff to ensure resident's healthcare needs are met. Treatment will be implemented as recommended and staff will ensure there is medical or multidisciplinary follow up where indicated.

Proposed Timescale: 21/10/2017

Theme: Health and Development

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

Some end of life care plans present in residents' plans were blank.

21. Action Required:

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

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

-End of life assessments for residents under Advanced Care Directives will be completed by staff in conjunction with the Palliative Care Clinical Nurse Specialist.

Proposed Timescale: 21/10/2017

Outcome 12. Medication Management

Theme: Health and Development

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

Appropriate and suitable practices relating to the ordering, receipt, storing and administration of medicines were not in place to ensure that any medicine that is kept in the designated centre is stored securely.

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:

-A medication audit will take place weekly by nurse management

-Staff practices in relation to all aspects of medication management to be addressed immediately.

-The CNM assigned to the house will supervise staff practice and address any deviation from safe medication management practices and non-adherence to Cheeverstown Medication Management Policy

-Individual staff will be held accountability for poor performance under performance management

Proposed Timescale: 21/10/2017

Theme: Health and Development

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

Appropriate and suitable practices relating to the administration of medicines was not in place.

23. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

-Cheeverstown has a Medication Administration Policy which is in place to guide nursing staff in their safe medication practice. Each nurse will be required to re-read this policy

and be held accountability for his/her practice against this policy (and NMBI guidelines). On reading the policy, the nurse will sign to re-enforce that he/she has read and understands the policy that guides his/her practice and that he/she is accountable for their practice.

-The manager assigned to the house will complete a medication audit weekly. This audit will be reported to the PIC/CNM2. The audit tool used will include observing staff practice and a review of the resident's medication kardex

-Cheeverstown will continue to promote reporting errors and near misses

-Medication errors will be discussed at team meetings fortnightly as a rolling agenda item from a team learning and overall learning perspective. The PIC is responsible to ensure team meetings happen monthly in each house and what the agenda includes. The PIC will attend at least every 2nd house team meeting. She will delegate the chairing of team meeting to CNM1s in her absence.

Proposed Timescale: 21/10/2017

Theme: Health and Development

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

Appropriate and suitable practices relating to the disposal of out of date medication was not in place.

24. Action Required:

Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

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

-Stock in all houses in DC4 has been audited since the date of inspection. This audit process will continue as a scheduled monthly audit cycle.

-The monthly stock audit has been updated to address out of date medication and 'returns to pharmacy'

-The manager assigned to houses is responsible for the medication audit of that house.

Proposed Timescale: 07/10/2017

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:

Some of the details contained within the statement of purpose in relation to the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 were not reflective of practice within the centre.

25. 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 in place for the Centre 4 will be updated to reflect governance changes, roster changes, residents changing needs and any other practices in line with Regulation 03(1)

Proposed Timescale: 21/10/2017

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:

A clearly defined management structure that identified the lines of authority, accountability, roles, and responsibility for all areas of service provision was not evident within the centre.

26. 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 PIC for DC4 is the CNM2 of designated centre. The PIC is supernumerary to the roster. The PIC will work primarily Monday to Friday 8-4pm

-The PIC is supported by 2wte CNM1s.

-CNM1s are assigned to houses within the designated centre and have specific roles to that nominated house(s).

-One CNM1 post is assigned to Sycamore 5.

-One CNM1 post is a job sharing post. Both of these managers are assigned to Sycamore 2 and Cedar 3 and will spend a minimum of 19.5 hours per week present in these houses giving direct supervision

-The CNM2/PIC will provide supervisory hours to Sycamore 6.

-The defined management structure and roles & responsibilities will be given to all staff of DC4.

Proposed Timescale: 21/10/2017

Theme: Leadership, Governance and Management

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

The management systems in place in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

27. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

-The newly defined management structure will ensure the delivery of safe and effective service, appropriate to resident's needs and ensuring these responses are correctly monitored.

-Each house has a dedicated manager accountable for the house. The assigned manager will dedicate a minimum or 19.5 hours weekly to supervision of the house.

-The manager will be present in the house for 80% of their shift providing onsite supervision and also mentoring and guiding good practice.

-The management team will be responsible for auditing against identified KPIs for the designated centre (including Personal Plans, Social Outcomes, Medication Management)

Proposed Timescale: 21/10/2017

Theme: Leadership, Governance and Management

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

Effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering was not taking place.

28. Action Required:

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

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

-All Personal Development Plans not completed within the past 12 months will be completed

-Personal Development Plans will be based on the roles & responsibilities of the staff grade and delegated responsibility to them relevant to their role.

-CNMs will agree a schedule of PDPs for staff allocated to them by the PIC

-CNMs will be held accountable for the completion of staff PDPs

-The Head of Cheeverstown Centre is responsible for the performance management of the PIC/CNM2 against key performance indicators

-The CNM2 is responsible for the performance management of CNM1s against key performance indicators

Proposed Timescale: 28/10/2017

Theme: Leadership, Governance and Management

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

Some staff spoken with identified they would raise concerns about the quality and safety of the care and support provided to residents, to managers not associated with the designated centre.

29. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

-With the recent appointment of a new PIC, the management team of DC4 is complete with a PIC/ CNM2 and 2 CNM1s.

-The management structure of DC4 will be explained to the staff of DC4 and be clearly available in each of the houses.

-If a manager from DC4 is not on duty, a staff nurse will be identified as the house lead.

Proposed Timescale: 28/10/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

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

30. 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:

-There has been a recent reassessment of the needs of the residents in DC4 due to changing needs

-The management team are making adjustments to staff rosters to meet the needs of residents.

-These changes reflect staffing numbers, qualifications and skill mix.

-The Statement of Purpose will be updated to reflect these changes

Proposed Timescale: 30/11/2017

Theme: Responsive Workforce

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

Residents were not receiving continuity of care and support due to the level of relief and agency staff members required to operate the centre.

31. Action Required:

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

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

-The management team are making adjustments to staff rosters to meet the needs of residents.

-2 new staff (1 staff nurse, 1 care staff) have commenced contract in DC4 since the date of inspection

-Core support staff have commenced within the DC since the date of inspection. These staff will work primarily in this designated centre and have an in-depth induction which includes Risk Assessments, providing support against assessed needs and fire evacuation procedures. These staff will be managed by the DC4 management team in conjunction with the Support Team Co-ordinator.

Proposed Timescale: 30/11/2017

Theme: Responsive Workforce

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

The rota in one house was not up-to-date.

The rota in another house did not reflect all members of staff working in the centre over a 24 hour period.

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 forward planned and available in each house. This is the responsibility of the PIC.

-The manager assigned to the house will be on the roster to each house. The roster is each house will be updated daily (if changes are required due to unforeseen leave) by the CNM or their nominee.

-All staff providing support to a house will be captured on the roster available in the house, including the night duty float providing support to residents in the house.

Proposed Timescale: 28/10/2017

Theme: Responsive Workforce

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

Some staff members required refresher training in the areas of fire safety, people moving and handling and behaviour de escalation techniques.

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 has reviewed all staff members requiring training and staff have been booked for training required
- One staff completed People Moving & Handling Training on 18th September and further staff are scheduled for 9th November & 5th December
- Staff in DC4 are scheduled to attend MAPA training in Dec 7th.
- One staff completed Fire safety training on 11th September and other DC4 staff are scheduled for 29th September and October 3rd.

Proposed Timescale: 28/10/2017

Theme: Responsive Workforce

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

There was no formal supervision system in place for all staff members.

34. 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 Head of Cheeverstown Centre will meet the PIC/CNM2 weekly for the period of this action plan and monthly following its completion on a formal basis as their supervisor.
- The PIC/ CNM2 will meet CNM1s weekly for the period of this action plan against agreed KPIs for each house, and fortnightly following its completion on a formal basis as supervisor to their grade
- The PIC and CNM1s will meet staff on a one to one supervision once a quarter and this meeting will be documented. Personal Development Plans will be completed annually.
- The management team will be supervising practice in the houses and will be based in the houses
- The management team will meet individual staff more frequently if required.
- The core support team for DC4 will have scheduled supervision meetings with the Support Team Co-Ordinator once a quarter. Personal Development Plans will be completed annually.

Proposed Timescale: 28/10/2017

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 staff training and development policy was in draft format dated 2017 and the admissions policy was awaiting board approval.

35. Action Required:

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

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

The Staff Training and Development Policy was finalised and circulated 25th September 2017.

The Admissions Policy will be circulated following Board approval in October 2017.

Proposed Timescale: 28/10/2017

Theme: Use of Information

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

The retrieval of some schedule 3 documents was difficult, and in some instance, documents were unavailable, out of date or blank within residents' files.

36. 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:

-Documents relating to individual residents will be reviewed and completed

-Responsibility for review of residents' documentation is with the CNM assigned to the house. The CNM may delegate this to keyworkers and if so, will follow up on this delegated task to ensure completion.

Proposed Timescale: 21/10/2017

