Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Ltd
Centre ID:	ORG-0012018
Centre county:	Dublin 6w
Email address:	info@cheeverstown.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Ltd
Provider Nominee:	Brian Gallagher
Person in charge:	Deirdre Corrigan
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	0

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
10 June 2014 10:00	10 June 2014 20:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first monitoring inspection of this centre. It took place over one day and reviewed 7 of the required outcomes in full to demonstrate compliance with the legislation and regulations. As part of the monitoring inspection the inspector met with residents and staff members. Inspectors observed practices and reviewed the documentation including personal plans, medical records, accident and incident reports, policies procedures and staff files.

The centre is designated as one of five centres managed by Cheeverstown House Ltd for adults with intellectual disability. It is a community based service. The accommodation consists of four individual houses in the local community. Care is provided for up to 15 people.

There were 15 people living in the centre at the time of the inspection. Houses accommodate both mixed and single gender adults and one of houses is single story and use for resident whose mobility needs require this.

The inspector found evidence of a commitment to provide care for a complexity of residents needs within a multidisciplinary framework while promoting the independence and the safety of the resident within a community environment. There was evidence of inclusion and involvement of residents and or their representatives. There was evidence that resident's diverse healthcare and psychosocial needs were well supported and promptly responded to by staff. Access to a range of allied services including psychological and mental health specialists was evident. Integral supportive governance systems included a director of service, person in charge,

clinical director, quality controller, psychological services and operation and environment manager. Residents expressed their satisfaction with both their places of residence and the opportunities they had to have meaningful work and recreation.

During the course of the inspection the inspector noted that a small number of staff from the community houses had not had fire training although all were scheduled to do so in September 2014. However, it was also noted that staff who are responsible for the campus and the community houses on an on-call basis at night had not had fire training in two years. This was brought to the attention of the provider who acted immediately and arranged training for 13 June 2014, two days after the inspection and agreed to provide documentary evidence of this to the Authority.

Areas for improvements were found to be required in the following areas:

Development of risk management policies
Development of centre-specific infection control policy.
Complete and detailed documentation of resident's healthcare needs assessment and review.
Adherence to mandatory training requirements
Medication management policy and procedures
End-of-life policy
Confirmation of compliance with the statuary fire Authority.

The inspector acknowledges that the provider had already commenced work in order to address the actions outlined in this report.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Judgement:
Compliant

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

Findings:
All residents had personal plans in place and there was evidence that these were reviewed consistently and at a minimum annually. The personal plans contained information based on a range of up to 15 possible outcomes including health, recreation, work, social net works, choice in routines, personal care needs and supports. There was evidence, and this was confirmed by the residents, that they participated in these plans and they were implemented in consultation with them. A resident informed the inspector that the plan was, among other things was "a way of seeing that he got his rights".

In most plans reviewed by the inspector the assessment and interventions of a range of allied disciplines was incorporated and integrated into the plans by the staff who compiled them. For example, dietary requirements or support with mobility and mental health needs and aspirations for social networks and development. Residents were encouraged to be involved in a range of interesting and meaningful activities. Almost all attended day centres or workshops attached to other agencies and pertinent to their needs and capacities. There were communication systems evident between these day services and the centre staff to ensure residents were safe and supported. A number of residents also had part time jobs in local services such as supermarket or crèches. Residents were also involved and supported to participate in recreational activities including bowling, going out for dinner or to the cinema, on day trips of their choosing and to organised activities including special Olympics or the club in Cheeverstown which was held weekly. The inspector observed that within the houses residents had their own personal recreational items such as televisions, books or knitting and music centres.

There was evidence observed of day-to-day strategies implemented including help with personal care and preparing meals, and personal shopping where appropriate to the capacity of the resident. Effective communication tools such as "social stories" and pictorial images were used to support residents with information and understanding.

Care was monitored via a number of processes. This included the holding of "complex needs meetings for multidisciplinary review and review by the integral mental health team as appropriate. These reviews take place regularly and were attended by the, psychological services and family or representatives and allied clinicians. Clinical reviews under the supervision of the clinical director also take place. The purpose of these reviews is to review current accommodation arrangements, and, remove or reduce restrictions/treatments or medications when no longer needed.

Transitions between centres were found to be managed in consultation with the residents and with opportunities for example, to meet with other residents and spend time in the proposed centre prior to any move taking place. A resident was able to describe this to the inspector. Records also indicated that the move was carefully considered by the management and clinical teams in the interests of all the residents involved. One of the houses is single story and residents whose mobility status altered were supported to move to this more suitable house where they could maintain more of their independence.

An audit of up to 8 personal plans reviewed demonstrated a good knowledge of the resident's preferences and capacities. An internal audit of the personal plans takes place and this is also a method by which the management monitor the implementation and outcome of the plans.

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

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

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

Findings:
Some improvements were required in the overall management of environmental risk. There was a signed and current health and safety statement in the centre. A location specific health and safety audit and action plan for each house was in the process of being developed.

The provider had commenced the review of the risk management policy as required but this had not as yet been fully completed. It did not specifically address the requirements

specified by the regulations or the corporate response to risk identification and management and learning from adverse events. A detailed risk register was maintained and this did contain evidence of identification and management of risk pertaining to accidents and incidents and clinical risk for residents. Incidents were audited and reports indicated that the data was analysed for themes and emerging issues.

There was a policy on the control of infection and staff were familiar with the procedures and could describe hand washing and cleaning procedures to inspectors. However, specific guidelines were not incorporated into the policy. Clinical waste was managed according to guidelines. There was an emergency plan which dealt with breakdowns in heating, water systems and fire safety evacuation procedures. Staff were able to articulate the arrangements for support and interim shelter in other nearby houses or the campus should this be required. Emergency numbers for such events and systems for contacting local emergency services were available. Inspectors were informed that each member of the management team carries an alarm system and after 21:00hrs there is a dedicated night manager over all of the centres. Although no generator is available in the event of an electricity fault notifications, to the authority in relation to a small number of these incidents has indicated they were of short duration. The campus does have a generator and if necessary for medical reasons residents could be facilitated in that location.

Due to the type of service, the use of specialist equipment is minimal. Nonetheless, examination of records demonstrated that equipment required for residents safety and comfort including a specialist beds and one hoist were serviced by contract and as required. There was evidence that the fleet of vehicles which is shared between a number of centres and located on the campus was insured and tested for road worthiness.

In practice procedures were safe and indicated that resident safety was prioritised. Where deemed necessary manual handling plans were in place for residents and falls assessment prevention and management guidelines including protocols for head injuries were also evident. Staff were aware of these protocols. Some improvement was required in the procedure outlined for the prevention of and actions required in the event of a resident going missing. However staff were able to inform the inspector of what they should do. The individual houses were observed to be suitable and safe for the residents with suitably adapted and assisted shower rooms and wheelchair accessible entrances and back gardens.

There was evidence that emergency lighting and fire fighting equipment was serviced annually and the fire alarm was serviced quarterly as required. Daily checks on exit doors and the fire alarm panel were undertaken and documented by staff. Records available indicated that between two and three fire drills had taken place in the individual houses since January 2014. The drills were held at various times including night time. Residents were involved and informed the inspector of the procedure in the event of the fire alarm going off. Improvements were required in the fire safety management systems however. Records indicated that while fire training had taken place for staff in January and February 2014 facilitated by a suitably qualified person, up to 6 staff working across the community houses had not undertaken his training. There were fire doors installed in the houses. However, in some instances one of the fire exits

was through a bedroom and the bed was positioned in a manner as to impede the exit, although it did not entirely block it. The provider is aware that he will be required to provide written evidence of compliance with the statutory fire authority by a competent person in order to achieve registration and to this end has commenced the process of having the individual houses inspected by a competent person

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

Judgement:
Compliant

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

Findings:
The inspector reviewed policies and procedures for the prevention, detection and response to allegations of adult abuse and found that they were satisfactory, clearly set out the responsibilities of designated personnel within the organisation and appropriate personnel in statutory services and reporting mechanisms in these matters. There is a designated officer for both adults and children's services identified. Staff were able to articulate their understanding and responsibility in relation to this.

In recognition of the fact that staff in some houses work primarily alone, the inspector was informed that a lone working policy was being developed and would include systems for monitoring staff and residents. It was however evident that although the current line managers do not attend at the houses daily there was regular phone contact between staff and line managers. Individual residents were supported with safety plans, and had issues such as travel training, recognition of unsafe situations, what to do in an emergency and how to use mobile phones. Residents told the inspector that they felt safe living in the centre and with the staff. There were good procedural guidelines on the provision of personal care to residents including respecting residents privacy and dignity. Examination of the training matrix demonstrated that staff had received training in the protection of vulnerable adults. Residents informed inspectors that they felt safe and well cared for by staff.

From a review of records, interviews and notifications forwarded to the Authority the inspector was satisfied that the provider took appropriate action in safeguarding residents and reviewing any alleged incidents in a timely manner.

There is a policy on the management of behaviour that is challenging and positive supportive plans were implemented. Staff have had training in the management of challenging behaviours and this is regularly updated. The strategies implemented and developed by the clinical team demonstrated an understanding of the meaning of behaviours for the residents based on their particular need and the staff spoken with demonstrated an understanding of this and the manner in which to support the resident.

The inspector found that restrictive procedures were minimal and where utilised they were reviewed by the rights committee and were proportionate to the risk. They included interventions such as holding a lighter for one resident to ensure his safety based on his assessed needs. Only one resident was using a bed rail and there was an assessment for the use and safety of this rail and the resident was monitored on an hourly basis. A low bed was also available for the resident.

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Judgement:
Non Compliant - Minor

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

Findings:
There was evidence of overall compliance with the regulations with some improvements required in the management of the documentation available in relation to this. Residents have a choice of general practitioner (GP) and may if they choose, and it is feasible, continue to attend their own GP. Staff maintain a record of all appointments and decisions and also liaise with families who may be the primary contact with the GP. Visits usually take place in clinics which is appropriate to the capacity and independence of the residents. Where this is not possible the inspector saw that the GP reviews the residents in the centre. Out of hours service is available. Records and interviews demonstrated that there was very regular access to medical practitioners and staff were observant and responsive to any changes in the healthcare status of the residents. There was evidence of regular access to opthalmatic services, hearing specialists, and dental and chiropody services available. There was evidence of referral and regular consultation with allied services as required by the residents, including physiotherapy, occupational therapists dietician and speech and language therapy. These services can be access internally and are referred via the GP. Clinical overview by psychiatric and psychological services is available to residents and to staff in an advisory capacity.

Residents who required modified consistency diets were reviewed by the speech and language therapist and recommendations made relating to the consistency of diet was

on display in the dining rooms. The direction was clear and staff were familiar with the instructions where this was deemed necessary food and fluid charts were maintained and monitored. Routine monitoring of health was undertaken including blood sugars weights and blood pressure and blood tests where required. The inspector found that protocols for the management of, for example, epilepsy were implemented, the medication required was available and the staff were able to inform the inspector of the agreed protocols and also the training they had and were receiving in relation to this. Further training is scheduled for July 2014.

However, due to the documentation used there was no composite health assessment and status documentation available and therefore the records did not provide full information on residents overall health status, changing health status or underlying conditions in some instances which is pertinent to the care provision. The staff however demonstrated knowledge of the health care status of the residents and this is primarily a deficit in the type of documentation available as opposed to any deficit in the provision of health care.

The policy on supporting residents at end of life was not as yet completed. However, a revised care plan had been developed and was in use in the centre for a resident. This plan demonstrated that consideration was being given at an appropriate stage to managing the social, emotional spiritual and healthcare needs of the resident in consultation with the families and the GP. Pain management monitoring was undertaken and records and interviews indicated that staff were observant and attentive to the resident changing needs. Staff informed the inspector that where resident's preferences are to remain in their home at the centre at the end of their life increased staffing and nursing support had been readily available and the palliative care services had also been accessed.

The houses in the centre are fully equipped with cooking and dining facilities in a very homely and domestic environment. Residents confirmed that as they wish and according to their capacity they do their own shopping, help staff with shopping and prepare their own meals including baking. They said they loved the food and always had choices. They could if they wished have friends over for meals and this was observed during the inspection. They prepared daily lunches if they were going out. Menus for the day were posted in suitable locations. The mealtime experience was observed to be enjoyable and social with good communication and support form staff. Dietary advice and guidance in terms of nutrition and healthy eating was evident.

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

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

Findings:
The current medication management policy was not sufficient to adequately guide practice in accordance with legislation and guidelines and was in the process of being revised. Currently it did not detail requirements such as the use of Pro-re-Nata (as required) medication and the use of controlled medications. There was evidence that medication was being reviewed regularly by the appropriate practitioner whether mental health or general. A small number of residents were self administering some medication and an assessment of the suitability of this had been undertaken. Training for staff in medication management was scheduled in order to ensure they were familiar with the revised procedures which included a revised medication administration record and systems for receipt of medication. A sample of medication management charts reviewed did not indicate any incidents or errors. A review of incident records indicated that any which did occur were found to be promptly reported and remedial actions taken. A medication audit was undertaken and any discrepancies were noted and acted upon.

Residents in some instances take their medication in the sealed folder to their day care centres. In other cases the medication is delivered to the day care and the staff there administer it. Staff in the centre then sign the administration record to indicate the medication has been administered. However, there is no communication system via the centre and the day care to ensure the medication had been administered to the resident. A documented system for the return of medication had been introduced. Where controlled medication was used the system for storing and recording were in place but the documentation for the administration of this medication was not in line with legislation and guidelines however.

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

Judgement:
Compliant

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

Findings:
Overall inspectors found that governance arrangements as implemented by the board of management were satisfactory and there was evidence of good governance and accountability. In order to ensure that the function of the service can be achieved, the voluntary board of management had put in place a professional operational management team. This included the nominee of the provider who is engaged full-time as the chief executive officer, and the director of services who is currently nominated as the person in charge. She is suitably qualified and experienced, engaged full time and demonstrated good knowledge of the regulatory and legislative requirements. There are suitable deputising arrangement in place. The team is also comprised of a clinical director, quality assurance manager and operations/environmental manager. The community services which this centre forms part of are also overseen by a clinical nurse manager (CNM) 3 and two CNM 2. A social care leader had also been appointed in each house. Reporting structures are clearly defined. Staff were clear on the management structure, reporting systems and areas of responsibility and residents were aware of the senior managers and their own local mangers.

The provider stated that it is intended to revise the current arrangements in order to formalise the management functions within the centre and appoint persons to the role of person in charge of the various community services in recognition of the size and variety of the services provided. Night time on call is undertaken by a night manager who is responsible for the 15 community houses and the campus.

A number of processes are used to monitor and oversee the safety and quality of care. These included the undertaking of three monthly and annual reviews of accidents and incidents from which remedial actions were identified and monitored for compliance. An annual analysis of incidents is also undertaken. Residents and relatives are involved service at various level which supports their inclusion in its development. There was evidence to demonstrate that the service overall was well managed and focused on development and good outcomes for residents.

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

Judgement:
Compliant

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

Findings:
From observation and rosters available the inspector was satisfied that both the skill mix and numbers of staff was satisfactory to meet the needs of the residents. Staffing levels and skill mix in each house were driven by the needs of the resident. Two of the houses have a nurse on duty due to the healthcare needs of the residents and one house has both a waking night staff and a sleepover staff. In other houses staff work primarily alone. Additional resource staff are allocated for specific periods for instance, a number of days per week to ensure residents activities, recreation or appointments can be facilitated. Agency and a small number of consistent relief staff are used to supplement the staff quota. As the residents are out during the day in most cases the house are not staffed until circa 15:00hrs in the afternoon. While there was no evidence in this instance that this impacted on the residents in any way the inspector was informed that without protected time it is difficult for the social care leaders to ensure follow up of for example, appointments and personal plans was undertaken.

The inspector reviewed the personal records for five staff of various grade and roles and found there was substantial compliance with the requirements including two references, Garda Síochána vetting, and evidence of qualifications and photographic identification. Files had been reviewed and missing documentation noted previously was in the process of being sourced. Files were found to be in good order with documentation easy to access. There was evidence of registration with the professional body where this was required. Volunteers were found to be suitably vetted and supervised in their roles. The provider has a contract with an agency which on occasion provides relief staff. The contract requires the agency to provide evidence that they have sourced all of the relevant documentation and clearances. The staff were trained in a range of suitable and varied disciplines including social care, social studies and or nursing and special needs and caring for people with disabilities. Staff on overnight duty in the centre must have an academic or professional qualification. There was evidence of annual appraisals and performance reviews undertaken which focused on training and development. Team meetings take place with the clinical nurse managers to monitor care.

Mandatory training requirements including safe moving and handling and the protection of vulnerable adults were up to date. The outcome on fire training has been detailed under Outcome 7. A range of internal training which is pertinent to the resident population is available for staff. This includes training in autism, introduction to dementia, challenging behaviours and CPI. Training in safe swallowing and palliative care had been provided to some staff. This training schedule was ongoing with 2014 already planned and included medication management and the management of epilepsy.

There was a knowledge and understanding of the standards and regulations evident. Staff spoken with demonstrated an in-depth understanding of the needs and wishes of the residents and competency in their work. Communication observed was found to be open, supportive, respectful and warm.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Ltd
Centre ID:	ORG-0012018
Date of Inspection:	10 June 2014
Date of response:	4 July 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not contain details of how risk would be identified and action to manage risk including the specific risks outlined in the regulations such as the unexplained absence of a resident, aggression and self harm.

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

Please state the actions you have taken or are planning to take:
The Provider will ensure that-
A Health Safety and Risk Management Policy Sub Group has been established to review

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

and update our current policy. This policy will include a Risk Assessment Form and will also contain procedures for:
a. Unexplained absence of residents.
b. Accidental Injury to residents, visitors and staff.
c. Aggression and violence.
d. Self Harm.

Proposed Timescale: 01/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Centre-specific systems to support the prevention and control of infection were not available.

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

Please state the actions you have taken or are planning to take:
The provider undertakes to develop centre specific systems to support the prevention and control of infection.

Proposed Timescale: 30/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Mandatory training for staff in fire safety and evacuation of residents had not been provided.

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:
Six night staff completed training on Friday, 13th June. A training plan is in place for refresher fire training in September & October 2014

Proposed Timescale: 31/10/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Policy for the support of residents at end of life was not developed.

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:
The Person in Charge will ensure that-
• An End of life policy is being developed in partnership with HSE Dublin-Mid-Leinster.
• A Guideline for Individual support plans at times of illness is being developed

Cheeverstown Guidelines available 31st August 2014
Policy Draft available 31st December, 2014.

Proposed Timescale: 31/12/2014

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:
Policy on medication management and systems for the management of controlled medication and medications which are given to residents attending day care services were not sufficiently robust.

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:
• Currently there is a medication policy committee who are in the process of a complete update of Cheeverstown's medication policy. Work has begun on ensuring that the above issues are actioned upon promptly and will all be fully operational by the end of July 2014.
• A review of the systems for the management of medication which are given to residents attending day care services is being undertaken.

Proposed Timescale: 19/09/2014