

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004130
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Limited
Provider Nominee:	Brian Gallagher
Lead inspector:	Deirdre Byrne
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	10
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
14 April 2015 09:30	14 April 2015 19:00
15 April 2015 08:30	15 April 2015 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This registration inspection was announced and took place over two days. The inspector observed practices and reviewed documentation such as personal plans, medical records, accident logs, policies and procedures and staff files. The inspector received questionnaires from residents which were complimentary of the service being provided at the centre.

The inspector visited the three units where residents resided, which formed the designated centre. The inspector met with residents and staff in these locations. The inspector also met the management of the service and a fit person interview was

carried out with the nominated person on behalf of the service. He was found to be knowledgeable of his role and the requirements of the Regulations. Despite a clearly defined management team with responsibility for the service, there was no nominated person in charge as required by the Regulations.

While the roles of clinical nurse managers is to provide clinical cover for all of the community services, there was a lack of governance in the designated centre to support this management structure to ensure that the needs of residents are met, incidents were appropriately responded too, personal plans implemented and staff were supervised.

As many of the residents were out during the day, part of the inspection took place in the late afternoon and evening, when residents had returned from their day activities. All residents had an intellectual disability.

Overall, the inspector found that residents received a good quality service, whereby staff supported and encouraged them to participate in the running of the house and to make choices about their lives. There were regular meetings for residents, however, residents' communication support needs needed to be enhanced. The inspector found that residents' healthcare needs were met as needs arose, however there were no care plans to guide the care. Residents were supported to develop and maintain personal relationships and links with the wider community.

The houses were clean and had a warm, hospitable atmosphere and the inspector found that the residents were comfortable and confident in talking about their home. However, not all of the premises met the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013. There was currently no plan to address the deficits in the premises.

While evidence of good practice was found in many of the outcomes, areas of non compliance with the Regulations were identified. These related to the provision of appropriate resources to support residents in one unit, the management of residents' finances in line with the policy, aspects of fire safety and the provision of training to staff around the specific care needs of residents and aspects of medication management. Other areas for improvement included the development and implementation of residents' personal plans, implementation of the risk management policies to guide staff practices, the complaints procedures, the contract for provision of services and the statement of purpose.

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

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

The inspector found the provider and staff had systems in place to ensure residents were involved and participated in decisions about their care and the organisation of the centre. However, some improvements were required in the consultation with residents and the management of complaints.

The centre was managed in a way that maximised residents' capacity to exercise personal independence and choice in their daily lives, with an area of improvement in relation to one resident, as outlined in Outcome 8 (safeguarding and safety). There were regular house meetings and it was clear that residents planned their day, routine and activities. In addition, an internal advocacy group met that included resident representatives. However, not all residents were consulted with about the findings and actions to be taken after the meetings.

Some residents had access to an external advocacy service. However, there was inconsistent information available in the centre on the different external advocacy services available to the residents.

There were policies and practices on the management of complaints in place however, there was no procedure publicly displayed in the houses. Therefore it was not clear how residents were supported to make complaints. The inspector was informed that complaints were reviewed and followed up on however, there were no records of complaints made available to the inspector. Staff informed the inspector that records were held at senior management level.

There were systems in place to support residents to manage their day to day monies required improvement. There were policies and procedures on the management of residents' finances. However, these were not fully implemented in practice. For example, where transactions were carried out on residents' behalf by staff, there was only one staff signature. This is discussed under Outcome 18 (Documentation).

Staff described the procedures to the inspector and outlined how residents were using the balance of their pension or disability allowance each week. In addition, staff carried out daily and weekly balance checks of residents' monies, and a sample checked by inspectors were found to be correct. There were audits carried out by the finance departments. The inspector was informed of suspected financial abuse identified in one audit. This is discussed in Outcomes 8 and 9 (notification of incidents).

Judgment:
Substantially Compliant

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector found there were systems in place to assess and meet resident's needs however, improvement was required to ensure all residents' communication needs were met.

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

Some residents were seen to have communication passports in place that gave an overview of their communication style, and other key information people may need to know about them. The inspector was informed that other residents were carrying them with them during their day activities so they were not available to view. In addition, not all of the residents had communication passports, or support plans that identified their communication needs and how they were to be met.

Through the inspection, the inspector saw that staff were communicating well with

residents, and understood their individual ways of speaking and communicating. Residents appeared confident in making themselves understood.

Residents had access to telephones, TV, radio, DVDs. Some also had access to mobile phones as was their choice. Residents were seen to be accessing local shops to buy papers and magazines of their choice.

Many of the policies and guidance documents were provided in an easy read format that would support some residents to understand them.

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):
This was the centre's first inspection by the Authority.

Findings:
The inspector was satisfied that the residents' were well supported to develop and maintain personal relationships and links with the wider community. This was also outlined in picture and word formation as one of the 'residents rights' as outlined in the Residents Guide.

Support plans set out the key relationships in residents' lives as part of their support network, and any support that was needed to maintain those relationships. There were records of the contact residents had with their family and others.

There were no relatives visiting at the time of the inspection. Residents spoken to confirmed that where they had relatives and friends who were important to them, they had been able to continue to have regular contact with them.

The inspector was informed by staff that family members and friends could visit at any time and that they looked forward to spending time with their family. Staff informed the inspector that some residents visited their family home regularly and often spent weekends and holidays with their family. Other residents had gone on holiday abroad with the support of staff members who know them very well.

The provider had a recreation and socialisation team in place to support front line staff and volunteers in the promotion of social activities, hobbies and leisure activities. The inspector found that this provided residents with an opportunity to lead full and

meaningful lives through active and healthy social and recreational activities.

All residents met during the inspection had lots of interesting things to do every evening. Activities included attending regular clubs, social nights out to local restaurants, pubs, cinemas and leisure centres, weekly discos, bowling and swimming. The ladies in one house enjoyed shopping and going for coffees the local shopping centre.

The residents were also supported to attend concerts to hear their favoritism groups. The inspector spoke with one resident who enjoyed listening to music, and staff outlined a plan for the resident to attend a music festival this summer.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The inspector reviewed and found that the admissions policy only briefly set out the arrangements for admitting new residents to the centre. The admission process explained to inspectors considered the wishes, needs and the safety of all residents in the centre. However, this was not fully included in the policy, and discussed under Outcome 18.

There was a contract of care in place to detail the supports, care and welfare of the residents in the designated centre. This was called the memo of service provision. This was supported by a "manage my money document". However, the contract of care did not fully include the details of the services to be provided for that resident.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to

meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

The inspector found each resident had a personal plan in place however, improvements were identified in the development of plans in line with the residents identified and assessed needs, and the information they contained to guide practice.

The inspector reviewed three of the plans. There was not a consistent approach to the development of the plans to ensure the residents needs and choices were identified and documented. The personal plans were available in an accessible format.

The records of the goal setting and evaluation of the plans did not demonstrate the good practices delivered. There was some evidence of regular review and participation of residents in the development of their plans. However, the assessment did not have multidisciplinary input and did not inform the personal plans. Staff were not fully aware of the residents' plans and they did not inform the service delivered. It was not apparent if the goals set had been achieved. The provider had acknowledged the deficits in the documentation and had recently introduced a new planning document and staff had received training. The inspector found that the new documentation addressed many of the deficits identified.

The personal plans contained important information such as details of family members and other people who are important in their lives, wishes and aspirations and information regarding residents' interests. The inspector also found that there was a lack of care plans to guide the care to residents, see Outcome 11.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Overall the centres physical design and layout met the requirements of the Regulations, with an area of improvement in one house identified. The centre comprised of three houses, all of which were visited by the inspector who found them to be well laid out and met the individual needs of the residents. The houses were clean, warm, well maintained and homely.

As reported above, there were three houses, located in the same geographic area.

Unit one was a two storey house. It consisted of four bedrooms (three single and one two bedded room), with two communal toilet and wash-hand basins, and one communal shower room. While the house was homely in its design, the layout of the ground floor bedroom and en-suite shower room did not fully meet the individual needs of the resident. The resident informed the inspector that their bedroom was too small. The en-suite shower room was not large enough for the resident to transfer from their wheelchair. While there was appropriate assistive equipment provided the resident could only be transferred into a shower chair in their bedroom due to lack of space in the ensuite.

The inspector also visited the two bedded room in the house, with resident's permission. There was no screening provided and no risk assessment to identify any risks to residents' privacy and the control measures (see outcome 7). The inspector was informed by staff, that at times it was difficult to provide sufficient privacy when providing intimate care if both residents were present in the room. While small in size, the room had sufficient room for storage and to personalise the space around residents' beds.

Unit two consisted of a two story house. There were four residents' bedrooms (all single occupancy). Two bedrooms had an en-suite with toilet and shower, and there were two communal toilets, one with a bath. The inspector visited one of the bedrooms with the permission of the resident. It was of adequate size to meet residents' individual needs. The design and layout of this house met the individual and collective needs of the residents.

Unit three was a two story house. There are four bedrooms (all single occupancy). There were two en-suite toilets with shower, and two communal bathrooms provided. The inspector visited one resident's bedroom with their permission. It was very nicely furnished and decorated. There was adequate space to personalise their room and had ample storage.

In the three houses, there were appropriate numbers of bathrooms, showers and toilets in the centre to meet the residents' needs. Each of the houses was provided with a kitchen/dining and sitting rooms. A pleasantly landscaped garden was accessible to residents both to the front and back of the houses. A separate office with bed for sleep

over staff was provided.

The centre was maintained to a high standard cleanliness and hygiene. Rooms were decorated in accordance with the wishes of the resident and contained personal items such as a television, family photographs, posters and various other belongings.

The inspector was informed that staff and the residents both carry out the cleaning procedures. There was suitable cleaning equipment provided.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

The inspector found there were measures in place to ensure the health and safety of residents, staff and visitors to the designated centre was promoted and protected. However, improvements were required in relation to the assessment of risk, the management of adverse events and aspects of fire safety.

The inspector found the assessment of risk required improvement. There was a risk management policy that met the requirements of the Regulations. However, it did not guide practice in relation to the risk assessment of all potential hazards in the centre. For example, the risk register only contained risk assessments of individual persons and no environmental risks were identified. In addition, a number of areas of potential risk identified by inspectors had not been assessed. For example, risk assessments for residents who smoked, shared bedrooms or who were at risk of choking. These matters were discussed with the assistant director of nursing (ADON) who described a pilot risk assessment of non person related risk carried out. A sample of the pilot risk assessments were seen by the inspector, and were found to contain comprehensive information. The ADON explained where risks were rated orange and red they were escalated to senior management for review, and were incorporated into the corporate risk register.

There was evidence of discussions in relation to issues such as the risk register, fire safety and the emergency plan. The minutes of health and safety meetings read confirmed this. A new safety inspection form had also been developed. It was envisaged safety representatives and clinical nurse managers would complete these inspections, which would pick up unidentified hazards, which would require risk assessment.

There were systems in place to manage adverse events. Risk management forms were read by inspectors, in which a range of incidents were recorded. While inspectors were informed and saw evidence that incidents were collated and reviewed, improvements were identified. For example, there was no evidence of what investigations had taken place following choking incidents or falls. In addition, there was no evidence of the action taken to prevent a similar incidents re-occurring.

A health and safety statement was seen by inspectors. The inspector read an emergency evacuation plan, which was provided in each house of the centre.

A suite of infection control procedures were also in place to guide best practice. However, they were not centre specific to guide staff practice (see outcome 18).

There were procedures in place on the management and prevention of fire. The inspector saw fire exits in each house were unobstructed and documented checks were completed by staff. There were regular fire drills during the day and night which involved residents and staff. These took place up to four times a year. Records were read of the drills carried out that included the findings and any learning required. The outcomes of drills were discussed at the above mentioned health and safety meetings. Residents informed the inspector they had taken part in the fire drills.

Staff were able to tell the inspector what they would do if the fire alarm went off. The inspector saw documented evidence that fire equipment was serviced regularly such as fire extinguishers, fire alarms and emergency lighting. Fire evacuation plans and notices were displayed throughout the centre. Records reviewed by the inspector indicated that all staff had participated in fire safety training.

The inspector was shown an externally contracted report outlining a comprehensive fire safety assessment of each house in the centre. A number of fire safety issues had been identified for example, there were no fire doors on the ground floor in one house, and an alternative emergency exit door was required for one resident. The provider had an action plan in place to address the deficits. An updated report was also submitted to the Authority after the inspection, that outlined what areas still required work to be carried out.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

This was the centre's first inspection by the Authority.

Findings:

There were arrangements in place to safeguard residents and protect them from the risk of abuse. However, one example showed improvement was needed in the timeliness of a response to one allegation.

The inspector reviewed policies and procedures for the prevention, detection and response to allegations of adult abuse and found that they were satisfactory. They 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.

The inspector reviewed records of allegations that had been made, and were satisfied that the provider generally took appropriate action in safeguarding residents and reviewing any alleged incidents in a timely manner. However, there was an incident of suspected financial abuse where a timely response had not been made and it was not notified to the Authority. Action was taken when this was drawn to the attention of the provider nominee.

Staff spoken with were knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. All staff had received training on safeguarding vulnerable adults. Further training was planned to include the national policy.

Residents who spoke with the inspector, and completed the questionnaire for HIQA all said 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. Each resident had an intimate care plan that set out their personal needs and how they were to be met.

There was a policy on the management of behaviour that is challenging. There was also a new policy that had been approved and was going to be circulated to staff. The new policy was strongly focused on the rights of residents, promoting positive approaches and identifying and addressing any underlying causes for resident's distress. Staff had training in the management of challenging behaviours and plans were in place to provide training on the new policy and procedure. 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.

Where residents needed support in relation to their behaviour, positive support plans were in place. The documents gave details on the residents history, how they

communicated, and the steps to support them when experiencing anxiety, or distress.

The inspector found that restrictive procedures were minimal and where they were in place, they were reviewed by the rights committee and were proportionate to the risk. They included interventions such as holding a lighter for one resident to ensure his safety, based on his assessed needs. Where residents were using bed rails and there were risk assessments completed, and the staff monitored residents on an hourly basis.

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector found the provider was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents.

While the provider had submitted notifiable incidents to the Authority, a suspected incident of suspected abuse (as discussed under Outcome 8) had not been notified. This was brought the director of services attention, and was subsequently notified. They had also provided three monthly notifications as required.

Judgment:

Substantially 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):

This was the centre's first inspection by the Authority.

Findings:

The inspector found each resident had opportunities for new experiences, social participation and activities that matched their preferences.

There was a policy on access to education and training. This committed to all residents being supported to engage in learning opportunities.

Records reviewed, and discussions held with residents and staff, confirmed residents had a variety of opportunities to engage. Each resident had their own weekly schedule that set out the range of activities they were involved in. The inspector read information, that was confirmed by staff, that residents had access to a range of different day services, attending groups, classes, having jobs and volunteering.

Staff informed the inspector that some residents visited family, had visitors in their homes, had parties, and attended shows and events in local entertainment venues.

The planning meetings between the residents and their key workers identified things residents wanted to achieve and some evidence was seen of these being met. It was noted that not all residents had goals identified for 2015, but work was ongoing for this, with more of a focus on charting their progress in achieving identified goals.

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

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The inspector found that there were appropriate arrangements in place to support residents' health care issues as they arose. The staff in the locations were very familiar with residents needs and had responded when the need arose. Staff had created links with the health services in the community and within Cheeverstown allied health professionals. However, improvements were identified in the assessment process and development of health care plans .

The inspector reviewed the personal plans and medical folders for three residents and found that they had access to a General Practitioner (GP), including an out of hour's service. There was evidence that residents accessed other health professionals such as chiropodists, opticians and dentists. There was some evidence that residents had accessed breast check.

Overall, there was a lack of evidence based assessments completed, for example, nutrition, falls and wounds. In addition, the inspector found care plans were not consistently developed for residents identified health care needs such as falls, epilepsy and swallowing (see Outcome 5). There was a lack of evidence that comprehensive health assessments were completed. The nurse managers said these were maintained in the GP surgery off site. Health plans were in place for residents, however, they did not provide sufficient information to guide care of residents and were not consistently up to date for all residents. For example, there was no record to show that staff responded when a residents blood results were irregular. There was no consistent follow through when the need for referrals to other services was identified. While residents were referred to and reviewed at the complex needs committee, there was insufficient evidence that issues were followed up through this meeting. The health plans did not include key information such as the residents who had swallowing problems.

The inspector found the residents appeared to enjoy their evening meal when they returned to the centre. Residents decided what they wanted for their evening meal and if any resident did not like what had been prepared, there was a range of alternatives available. Residents were supported to have or to make a snack at any time of the day or night. Residents enjoyed going out for a meal and at times they participated in doing the household shopping.

The inspector found that there was an ample supply of fresh and frozen food. Fresh fruit and juice was available during the day which residents could access.

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):
This was the centre's first inspection by the Authority.

Findings:
The inspector was satisfied that each resident was protected by the designated centres policies and procedures for medication management.

The inspector read a sample of completed prescription and administration records and saw that overall they were in line with best practice guidelines. The pharmacist was involved in medication safety and provided support and advice as required. Information pertaining to each resident's medication was available in the resident's files.

Staff had received training in this area and were familiar with the medications in use. There were no medications that required strict controls in place, but staff outlined the procedure they would follow. Staff knew about the procedures for reporting medication errors. However, there were no reports available in the locations, therefore the inspector was unable to ascertain whether appropriate action and learning to prevent similar occurring.

There was a policy in place to guide safe practice in residents who choose to self medicate. There were no residents self administering medicating in the centre at the time of the inspection.

Medication audits were not completed for each location to identify areas for improvement. Therefore there was a missed opportunity for learning, this is discussed in more detail in Outcome 14.

Judgment:
Compliant

Outcome 13: Statement of Purpose

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

Theme:
Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

The inspector found there was a statement of purpose in place. Although it contained the information required by the Regulations, it was not centre specific and did not accurately reflect the centre.

The inspector reviewed the Statement of Purpose for the centre. It contained information required by Schedule 1 of the Regulations. However, improvements were required as the information contained in the document were not specific to the centre. For example, the admission criteria, the organisation structure and whole time equivalent staffing arrangements. This was discussed at the feedback meeting with senior management who agreed it would be addressed.

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector was concerned that the provider had not nominated a person in charge as per the requirements of the Regulations.

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

There was a senior management team in place. The team included the provider, director of service, assistant director of services, medical director, financial controller, operations and quality manager, human resources manager, employment and training manager. In the designated centre, a team of local managers oversaw the day to day running of the centre, and these staff were clear on the management structure, reporting systems and areas of responsibility. However, the lines of accountability and responsibility for the provision of the designated centre at unit level were not so clear to ensure residents health, social and physical care and support needs were met were not robust, as evidenced in Outcomes 5, 8 and 11.

The inspector found that the management systems in place did not ensure that services provided are safe, appropriate to residents' needs, consistent and effectively monitored as outlined throughout the report. While the roles of clinical nurse managers is to provide cover for all of the community services, they were not supported in their role, as there was a lack of governance in the designated centre to ensure that the needs of residents are met, incidents are responded too, personal plans implemented and staff supervised.

The provider had established monthly clinical nurse manager meetings and it was planned that the clinical nurse managers would hold bi-monthly staff meetings in each location. The inspector noted there were gaps of four months in the minutes of the meetings, meaning staff didn't formally meet management for these periods of time. While staff said they have access to the nurse managers by phone, the management style was reactive rather than a planned approach to the management of the service.

The provider had undertaken two reviews of the service. The management team were working through the action plans from the previous inspection. The centre had been externally accredited for quality. The provider had established a management structure, however, the roles of managers and staff were not clearly set out and understood.

There were no audits available for review. The provider had carried out un-announced visits and this took place up to twice a year. An annual report of the quality and safety of care and support in the designated centre was not available.

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):

This was the centre's first inspection by the Authority.

Findings:

As there was no nominated person in charge in the designated centre, the inspector was unable to fully review this outcome against the Regulations.

Judgment:
Non Compliant - Major

Outcome 16: Use of Resources

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

Theme:
Use of Resources

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

This was the centre's first inspection by the Authority.

Findings:

The inspector found that resources were provided at times to support residents to meet their individual support plans however, an area of improvement was identified in one unit of the centre to ensure all residents needs were met.

In one unit of the centre, suitable staff resources were not fully in place to support residents to meet their needs. For example, one resident wore a continence pad at night time as there was no waking staff rostered. The resident required the assistance of at least one staff to transfer out of bed using a hoist. This matter had been reported on a number of occasions by staff, but there was no evidence of what action had been taken or improvement made. This was discussed with staff and management who agreed to follow up the matter.

Staff were involved in a range of activities, including assisting residents with personal care, carrying out household tasks, cooking meals, supporting trips out to local shops, supporting residents to attend medical appointments and spending time speaking with the residents.

Where required the provider ensured residents had access to one to one staffing assistance to ensure residents requiring high level supports could access activities of their choice, for example daily trips to town to buy newspapers, dining out, leisure activities and holidays.

However, while there was a team of committed and knowledgeable clinical nurse managers (CNMs) employed, due to their caseload they were unable to visit the designated centre frequently or provide a consistent level of supervision for the social care staff working there. CNMs told inspectors that they communicated with staff mainly by phone, and provided advice and support mainly over the telephone. Staff confirmed that CNMs were always accessible by phone, and that the CNMs visited the centre every few months. The inspector was concerned that the lack of appropriate supervision on a consistent could result in poor outcomes for residents.

The provider had ensured that sufficient personal equipment had been provided, for example, where required with aids and appliances to promote residents independence, for example electric beds and wheelchairs, alternating pressure relieving mattresses.

Judgment:

Non Compliant - Moderate

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):

This was the centre's first inspection by the Authority.

Findings:

Overall, the inspector found that staff were committed to providing a quality service to residents and there was a sufficient staff skill mix to meet the assessed needs of residents. However, the number and management of staff to ensure the provision of appropriate support care and supervision of residents required improvement.

The inspector found there were sufficient staff during the day however, an adequate number of staff was not in place in one unit at night time. As described in Outcome 16, one resident in one unit required assistance of a staff to transfer and mobilise however, as there were no waking staff rostered in the house at night time, this resulted in negative outcomes for this resident.

The inspector was not satisfied that the supervision of staff appropriate to their role was adequate. This was evident in the non compliances identified in Outcomes 5, 8 and 11.

There was a training programme in place for all staff. Records read by inspectors confirmed nearly all staff had up-to-date mandatory training and received education and training to meet the needs of residents, with training dates where staff had yet to complete training in fire safety. Records confirmed staff had attended a range of training in areas such as eating-drinking-swallowing, epilepsy, and behaviours that challenge. However, staff had not received training to care for residents specific needs, for example, diabetes, mental health and risk management.

The inspector reviewed a sample of staff files and found recruitment practices were in line with the Regulations. There was evidence nursing staff were registered with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2014.

All staff completed a performance review on an annual basis. However, this had yet to be rolled out for relief staff.

A small number of agency staff were used from time to time. The provider had a service level agreement with the agency, as read by inspectors. It confirmed that staff documentation was maintained and mandatory training provided as per the Regulations.

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

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:
Use of Information

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

This was the centre's first inspection by the Authority.

Findings:

The inspector found that the records listed in Schedules 2, 3 and 4 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. An area of improvement was identified in relation the policies in place.

The provider had ensured the designated centre all of the written operational policies as required by Schedule 5 of the Regulations. The inspector found that all policies required by Regulations were in place, however, there were some areas for further improvement. For example, the residents personal finances policy and the risk management policy was not implemented in practice as outlined in Outcome 1 and 7.

While the policies while informative and evidenced based, some were not centre specific and therefore did not guide practice, for example the infection control policy. As a result, there were no cleansing gels in place for visitors or staff to clean their hands to minimise risk of infection.

A number of policies did not contain an implementation date, review date and had not been signed as approved by management.

Judgment:
Substantially Compliant

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:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004130
Date of Inspection:	14 and 15 April 2015
Date of response:	18 June 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Residents were not consistently provided with feedback from internal advocacy meetings carried out.

Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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

and participates in the organisation of the designated centre.

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

Information pertaining to advocacy services will be made available in each residence. The local elected advocacy representative will visit all homes and share advocacy information and feedback from meetings with all residents. Commenced May 2015

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

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

The complaints procedure was not on display.

Action Required:

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

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

The accessible version of the Complaints Procedures will be on display in each residence; this will include a picture of the Complaints Officer, contact details and details of the Appeals Process.

The full Complaints Policy is also available in each house but not on public display

Proposed Timescale: 31/05/2015

Theme: Individualised Supports and Care

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

Information pertaining to the different advocacy services was not available to all residents.

Action Required:

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

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

Information pertaining to the National Advocacy Services has been made available in each residence.

Proposed Timescale: 31/05/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Residents communication needs were not consistently set out in their personal plan.

Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

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

Proposed Timescale:

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The agreement for each resident was not in line with the regulations.

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 service will ensure that the agreement for each resident (Memorandum of Understanding) is in line with the regulations.

In this regard the Memorandum of Understanding will state the amount of each resident's long stay charge following their assessment

Proposed Timescale: 30/06/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

Personal plans did not reflect the assessed needs of residents.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

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

Proposed Timescale:

Theme: Effective Services

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

The assessment did not have multidisciplinary input and did not assess the effectiveness of the plan.

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

Proposed Timescale:**Outcome 06: Safe and suitable premises**

Theme: Effective Services

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

A single bedroom as described in the report was not of suitable size to meet the residents needs.

The en-suite shower room described in the report was not of suitable size to meet the residents needs.

Action Required:

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

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

The action plan submitted by the provider does not satisfactorily address this failing

identified in this report.

Proposed Timescale:

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The risk management policy was not being implemented in practice in relation to the identification, assessment and management of risk.

Action Required:

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

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

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

Proposed Timescale:

Theme: Effective Services

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

There were a number of deficits in relation to fire safety in the designated centre for example, fire doors and an alternative fire escape exit in one unit.

Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

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

Proposed Timescale:

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

A timely response to an incident of suspected abuse was not carried out.

Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

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

Proposed Timescale:

Outcome 09: Notification of Incidents

Theme: Safe Services

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

An incident of suspected abuse had not been notified to the Chief Inspector.

Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

This issue of suspected financial abuse has now been addressed and notified to the chief Inspector.

Proposed Timescale: 18/06/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

The health action plans were not specific to guide the care to be delivered.

There was a lack of evidence that comprehensive health assessments were completed or care plans developed to guide practice.

Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

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

Proposed Timescale:

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not fully meet the requirements of the Regulations.

Action Required:

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

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

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

Proposed Timescale:

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

There was no nominated person in charge of the designated centre as required by the Regulations.

Action Required:

Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

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

The Person In Charge has now been appointed and the service is processing the necessary paperwork for submission to the registration department in HIQA

The required documentation was not received by the Authority.

"AT THE TIME OF REVIEW THE DOCUMENTATION WAS NOT RECEIVED BY

THE AUTHORITY"

Proposed Timescale: 12/06/2015

Theme: Leadership, Governance and Management

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

Staff were not supported within their role by the management team

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:

Staff will be supported by monthly meetings, bi-monthly meetings, performance management development systems, on duty management system, and out of hours on-call system. A review of these management supports to staff will be undertaken.

A management contact book has been established to record evidence of management contact with houses.

Each house will use their own communication book to log manager's contact with each house.

A plan will be developed to provide support to the management function.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

There was no annual review of the quality and safety of care.

Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

The service will provide an annual report of the Quality and Safety of Care and support.

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

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

The management systems did not ensure the service delivery of services appropriate to the residents needs.

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

Proposed Timescale:

Outcome 16: Use of Resources

Theme: Use of Resources

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

The inspector found that there were insufficient resources had been provided at times to meet the needs of residents.

Action Required:

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

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

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

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was an inadequate number of staff rostered in one unit at night time.

Action Required:

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

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

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

Proposed Timescale:

Theme: Responsive Workforce

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

Staff did not have access to training as outlined in outcome 17.

Action Required:

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

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

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

Proposed Timescale:

Theme: Responsive Workforce

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

There was no system of staff supervision.

Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

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

Proposed Timescale:

Outcome 18: Records and documentation

Theme: Use of Information

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

The policies in place did not consistently guide practice or were centre specific as outlined in the report for example, infection control.

Some policies in place were not implemented in practice for example, the residents' personal finances and risk management policy.

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:

Existing policies will be reinforced and implemented. The roll out of staff training on the identified policies will ensure consistent implementation

Proposed Timescale: 30/09/2015