Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004131
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Limited
Provider Nominee:	Paula O'Reilly
Lead inspector:	Deirdre Byrne
Support inspector(s):	Anna Doyle;
Type of inspection	Announced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
03 November 2015 08:00	03 November 2015 21:00
04 November 2015 15:00	04 November 2015 18:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The inspection took place to assess 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 of Residential Services for Children and Adults with Disabilities. Inspectors also followed up on areas of non compliance identified at the previous inspection, which had taken place to inform a registration decision on 14 and 15 April 2015. At that inspection a significant number of non compliances were identified, with 24 actions required.

As part of this inspection, inspectors met with residents' and staff members, observed practices and reviewed documentation such as personal plans, accident logs, policies and procedures. At the time of the inspection, 11 residents' resided in the designated centre which comprised of five units (houses) based in a suburban residential part of Dublin. Four houses were occupied. One house was unoccupied.

The provider had applied to register this house which was also inspected.

Inspectors found that good progress had been made in addressing the non compliances from the previous inspection. Since the last inspection, a person in charge had been nominated to oversee the service. The person in charge previously attended a meeting in the Authority offices and had been met at previous inspections of the centre. He was very familiar with the residents' health and social care needs, demonstrated good knowledge of the requirements of the Regulations and he was familiar with his responsibilities therein.

Staff were observed to treat the residents' in a patient, respectful and friendly manner, and were knowledgeable of their social and health care needs. Inspectors found good practices in the management of complaints and an accessible user friendly procedure was displayed in each unit of the centre. The residents' led independent lives and had interesting things to do during the day. There were good systems in place to support residents to transition within the service. However, the documentation, development and review of residents' personal plans required review. Due to the layout and size of residents' files, information was not easily accessible.

The residents' had access to medical, pharmaceutical and a range of allied health professionals, and where requested by residents, this was facilitated, and their right to refuse was respected. However, improved practices were required to document residents' identified health care needs and aspects of medication management.

The houses were maintained in good repair, nicely decorated and homely for the residents who lived in them. There were systems in place to protect residents' and staff. However, improvements were identified in the management of risk and fire safety required improvement.

There were good systems in place to meet with staff and meetings were taking place. There was an adequate staff skill mix and numbers in place. However, staff supervision and mandatory training required improvement.

There was a new person in charge of the centre. However, the person in charge was occasionally covering two other community designated centres, and improvements were required to ensure adequate governance of the centre was maintained on a day to day basis. The monitoring of the quality of care provided in the centre also required improvement as there was no annual review of the safety and quality of care in the centre carried out.

There were 24 actions from the previous inspection, 13 actions were completed, 8 were not addressed and 3 were in progress.

These and all other matters are outlined in the report and Action plan at the end of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors 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 relation to the complaints policy and ensuring privacy of residents' personal information was maintained.

The centre was managed in a way that maximised resident's capacity to exercise personal independence and choice in their daily lives. There were regular house meetings taking place in each house and it was clear that residents planned their day, routine and activities. However, minutes of these meetings were kept in a book together with minutes of staff and management meetings. This did not ensure the privacy of either parties. Inspectors noted that there was no evidence that issues brought up by residents were addressed as minutes of previous meetings were not reviewed at subsequent meetings.

Staff respected residents' privacy and dignity and there were blinds and curtains on their windows. However, inspectors found personal and confidential information in relation to a number of residents' was displayed in communal areas such as the kitchen. Also, staff notices and information pertaining to them was displayed in the residents' communal rooms although there was a staff office in each of the houses.

Inspectors saw evidence that residents had access to and met the internal advocacy representatives for the organisation. There was a photo of the representative and dates of upcoming meetings on display in the houses of the centre. The contact details of the National Advocacy Committee were displayed in each house together with lots of

information about the residents' rights. This was an action at the last inspection and had been completed.

Inspectors were informed that the residents were registered to vote from their home and those who choice to exercised that right.

There were policies and practices on the management of complaints in place and a copy was on display in each of the houses. This was an improvement from the last inspection. Inspectors saw complaints were dealt with promptly at local level. Records of closed complaints stated they had been resolved. However, there was no documentation of the investigation, the outcome and level of satisfaction of the complainant in one house where complaints had been reviewed and this required improvement. The policy required review to ensure it reflected the good practices. The person nominated to deal with complaints needed to be identified in each house together with the appeals person and person responsible for reviewing complaints.

There were policies and procedures on the management of residents' finances and systems in place to support residents to manage their day to day monies. A sample were checked by inspectors were found to be correct with receipts in place for all expenditures. Staff had systems in place to check each residents' balance daily. There were audits carried out by the management team and finance departments.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found there were systems in place to assess and meet resident's needs and 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.

Residents had their communication needs assessed on admission. Overall these were detailed and reflected the resident in question communication needs. Residents with communication needs had communication passports in place that gave an overview of

their communication style, and other key information people may need to know about them.

Throughout the inspection, inspectors 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 told inspectors they lived close to local shops where they could 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:
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found the provider had reviewed the admission policy and contract of care since the last inspection however, both required further review.

The admission policy had been reviewed in March 2015. The policy was not comprehensive to fully reflect the admissions and transfers processes practiced in the centre. For example, it did not refer to issues such as residents' and their next of kin being invited to visit the house, involvement in the decoration or the option to stay overnight; the consultation that takes place with the residents already living in a house; and the pre-admission assessment carried out. This is actioned in Outcome 18 (Records).

A contract of care was reviewed and it was called the memorandum of service provision. It included written and pictorial information regarding the services and facilities provided in the centre. However, it did not include what utilities were to be paid, or access to which members of the allied health care team was included in the monthly fee. In addition, it did not outline what additional charges could be charged to the resident. The document was signed and dated by the resident or their respective next of kin however,

it was not signed by the provider, person in charge or a representative from the centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors found each resident's wellbeing was maintained by a good standard of care and support. However, improvements were identified in the development and review of personal plans for residents. There were good practices in the provision of and access to opportunities to participate in meaningful activities appropriate to their interests also required improvement.

The residents' welfare and wellbeing was maintained by a good standard of care and support, by staff who were familiar with their social care needs. The residents' identified needs ranged from a mild to moderate intellectual disability which required staff support and assistance. Inspectors reviewed the personal plans of two residents. However, the files were contained within five large folders, therefore making it difficult for staff to identify the most up-to-date information on each resident. Furthermore, information was not up-to-date in all folders read. For example, historical information and letters were alongside current information. This is discussed further under Outcome 18. Inspectors were informed that work was taking place on removing excess information from residents' files.

The personal plans for residents social care needs were called "personal outcome measures" (POMs). Each resident had a POM assessment which was completed by a key worker in consultation with the resident. Inspectors spoke to two residents who were very aware of their goals and one resident showed a poster in her bedroom that summarised each goal. Their files were available to each resident however, they were not in an accessible format for residents to understand. Where residents refused to be involved in an assessment this was acknowledged and clearly recorded.

The personal plans reviewed were holistic and focused on a varied aspect of residents' lives, such as moving into a new home in the community, making new friends, going on holidays or trips. There were monthly evaluations of the residents' goals. However, these were limited. For example, discussions were limited to one goal. In addition, there was no evidence of multi-disciplinary input, residents involvement in the reviews, and if the goals had been effective or not. These were issues at the previous inspection and not completed. There was new personal plan documentation was seen by inspectors which was expected would address the issues. However, inspectors had been informed of this at the previous inspection in April 2015 and it was not yet been rolled out.

The overall documentation of care plans for residents identified healthcare needs required improvement. Inspectors found the residents had a range of identified healthcare needs however, care plans were not clearly developed to guide staff on the care to be delivered. For example, sleep apnoea, obesity, falls risk, mental health, bedrails and hoist usage. In addition, there was no evidence of regular assessment of residents health care needs to ascertain any changes in their health care needs. This is discussed further in Outcome 11 (Healthcare needs).

The person in charge ensured each resident had interesting things to do during the day in line with their assessed needs. Inspectors found some of the residents attend a number of activities and day services both internal and external to the service. Inspectors met a resident who told them about the job he took part in. Another resident was retired and enjoyed activities during the day such a walks and going to the shop. Residents told inspectors they enjoyed going shopping and for coffee or to the gym. Two residents talked about going out to watch football matches together, and sometimes to a local public house. One group of residents told inspectors about meals out together that they enjoyed.

Residents were supported when moving within the service. Inspectors met one resident who was transitioning within the organisation to a new home in the centre. Their new house was inspected as part of this inspection, and this is discussed in Outcome 6 (premises). In the interim the resident was living in one house in the designated centre until the new home was ready to move into. The transition was a carefully coordinated, organised and planned process with evidence of good consultation with the resident and their family. A plan was seen by inspectors that included skills development and learning for example, basic domestic and cooking tasks. The transition plan was not in an accessible version for the resident to understand. However, the resident was aware of the plans and told inspectors about the move and how much how they looked forward to it.

An assessment of the residents needs had been completed, which included a risk assessment of their new home. Inspectors were told the resident had a choice in how they will decorate the house. For continuity of care, the same staff working with the residents will continue to support her after transition. Inspectors spoke to the staff who described the positive impact the move has been having on the resident and how their quality of life had improved greatly. For example, she was carrying out more household tasks during the day and going out during the day to events such as art exhibitions, which she also told inspectors about.

Judgment:
Substantially Compliant

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:
Inspectors reviewed one component of this outcome in relation to the new house the provider had applied to register. As discussed in Outcome 5, it would form part of the designated centre. Inspectors found the house was in line with the Statement of Purpose and met the requirements of the Regulations.

The house is a one storey one bedroom semi detached house. It has occupancy for one person. It is located in a suburban residential area, in close proximity to local shops and the community. The entrance opens into a pleasant entrance/hallway. The bedroom is off the entrance hall. It has adequate space and storage for clothing and personal possessions. There is a spacious open plan kitchen-dining-living area, with a large window providing natural light. A shower room with toilet and wash hand basin is also provided. A staff office is provided and there is ample storage for equipment provided. The house has been tastefully finished, with tiled and carpeted flooring. There was more decoration to be carried out in consultation with the resident. A large garden is directly accessible from the house and it has been nicely landscaped.

Inspectors were shown around the house by the occupational health manager who is involved in the transition programme for residents. She was involved in identifying and assessing the suitability of the house for the resident who has been identified to live in it (this is discussed in Outcome 5 in more detail). The house has been provided with planning compliance certification which was forwarded to the Authority after the inspection.

There are four other houses in the centre are located in suburban residential areas of Dublin. They are all occupied, and these were also inspected at this and the previous inspection and met the requirements of the Regulations.

Judgment:

Compliant

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

Theme:
Effective Services

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

Findings:
Inspectors found there were systems in place to promote and protect the health and safety of residents, staff and visitors to the designated centre. However, the implementation of the risk management policy and the systems in place to contain fire required improvement.

A risk management policy was seen by inspectors that met the requirements of the Regulations. However, the policy was not fully implemented in practice. While a safety statement was seen and it included the environmental issues in each house, risk assessments on the environment and work place at unit level had not yet been carried out or any control measures to mitigate any risks. This had been an action at the previous inspection and was not addressed. The provider described the plans to address this. A draft risk register was shown to inspectors and there was a plan to roll this out to all houses. It was envisaged that once risk registers were developed they would be maintained and updated at local level. Since the last inspection, staff had completed training on risk management and this was confirmed by staff.

There were policies and procedures relating to health and safety and these were seen in practice. Since the last inspection safety audits were completed. The inspection forms read by inspectors confirmed these checks included a range of health and safety issues including maintenance and fire safety. Where issues were identified such as maintenance risks, these would be brought to the attention of the properties manager.

Inspectors found there was no infection control policy in place. There were generic guidance documents from the Health Service Executive to support staff. While there were no current infections in the houses, there was no centre specific guidance to inform staff. This was an action at the previous inspection and was not addressed.

There was an organisation wide emergency plan and staff were familiar with it. However, alternative accommodation in the event of an unplanned evacuation was not identified. This was discussed at feedback.

There were procedures in place on the management and prevention of fire. In each house fire procedures were prominently displayed. There was evidence of fire safety training provided to staff, with some gaps identified as some staff had not completed

up-to-date refresher training. All staff spoken to knew what to do in the event of a fire. There were regular fire drills and unannounced fire evacuations were carried out by staff at suitable intervals, including night time. Inspectors read records of fire drills carried out and they included learning outcomes. Residents informed the inspector they had taken part in the fire drills.

There was evidence that fire equipment was serviced regularly, with the fire extinguishers, fire alarms and emergency lighting serviced as per the standards. Inspectors found all fire exits were unobstructed on the day of inspection and documented checks were completed by staff on a daily basis.

Since the last inspection fire doors were being installed throughout the centre however, a number of fire doors had yet to be installed in four of the five units. A list of the areas where deficits were identified was shown to inspectors. It included the location of where the fire doors had yet to be fitted. Inspectors were assured that these works were being prioritised. Following the inspection senior management confirmed that works will be completed by February 2016.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. Overall, this outcome was compliant.

There was a policy on safeguarding residents from abuse which contained guidelines on how any allegations of abuse would be managed. The provider had appointed a designated adult protection officer. The responsibilities for this person were contained in the policy, and the officer was a resource to staff should they need to discuss any concerns they had.

Staff were generally knowledgeable about what constituted abuse and how they would

respond to any suspicions of abuse. Records were read of training provided to staff on safeguarding vulnerable adults. However, five staff had not completed refresher training, this is discussed under Outcome 17.

Residents were knowledgeable of who they could talk to if the need arises. There was evidence that incidents of allegations of abuse were appropriately investigated and managed in accordance with the centres policy. Inspectors met the person in charge and the manager deputising for the person in charge. Both were knowledgeable of the procedures in place to report allegations of abuse. She was supported by the designated person who organised the investigations to be carried out.

Throughout the inspection, inspectors noted that staff interacted with residents in a kind, caring, respectful and patient manner. Staff maintained residents' privacy during the delivery of intimate care. All residents had an intimate care plan in place, which guided care.

There was a policy on the management of behaviours that challenged, which was being used to guide the care delivered. Staff had training in the management of challenging behaviours. There was evidence that the GP, psychology and psychiatric services were involved in the care as required. Throughout the inspection, as identified above, the inspector noted that staff interacted with residents in a kind, caring, respectful and patient manner.

Residents had communication passports which included the behaviour support plans in place for all residents with behaviour that challenges. Two residents' who required support with their responsive behaviours had a positive support plan in place. The support plans reviewed guided staff practice on how to manage the behaviours.

There was very little use of restrictive practices in use in the centre. These were limited to bedrails and lap belts. Inspectors read risk assessment completed, and there were checks carried out by the staff when these were in place. To ensure residents' rights were respected, night checks took place once a night, and therefore residents' were not disturbed over night. Residents' who required this were reviewed at the rights committee

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):

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

Findings:
Inspector found the provider had systems in place to ensure residents' healthcare needs were met. However, improvements were identified in relation to reviewing residents' healthcare needs and the development of healthcare plans.

An annual assessment of residents' healthcare needs was called a "health profile screening tool" was completed by staff. A general overview of each residents' healthcare needs was outlined in the document. In addition, a health action plan was also seen by inspectors.

Inspectors read information on residents' files that provided guidance on the management of epilepsy or for the use of their hoist on their bedroom wall. However, care plans were not developed for residents' identified healthcare needs to provide guidance to staff. For example, dysphagia, falls and sleep apnoea. There was insufficient information for staff to follow to ensure residents health care needs were met. These were issues at the previous inspection also, and are actioned under Outcome 5 (Social Care Needs).

Inspectors reviewed records that confirmed residents' had access to the services of a medical practitioner of their choice. Records and interviews demonstrated that there was regular access to the GP and staff were observant and responsive to any changes in the health care status of the residents.

There was access to psychiatric services and psychology services within the organisation. The psychology team provided further service for behavioural management and support for residents. There was evidence that where a resident refused treatment or intervention this was documented but also that every support was afforded.

Inspectors saw information that residents' had access to allied services such as dietician, occupational therapy, physiotherapy, speech and language therapy and chiropody. However, letters of referral and visits were not kept in order of date visited with historical information stored alongside up-to-date information. It was difficult to identify residents' most up-to-date appointments and next appointments as this information was not clearly recorded and stored on their files. See outcome 18.

There were good practices in place for residents' to make healthy living choices around food. The residents' meals were prepared by the staff in three of the houses. In accordance with residents' assessed needs in another house, the meals were being delivered there from a central kitchen. The menu for the week was decided at the house meetings and it was displayed in the kitchen. The residents' were observed having their evening meal in one unit during the inspection. The meal was freshly prepared and looked very wholesome. Inspectors observed the fridge and cupboards in each unit were stocked with plenty of foodstuffs including fresh fruit and vegetables.

The residents' were supported to make their own meals and were also shown how to develop skills such a preparation of meals. In one house a resident told inspectors about

the meals he liked to prepare. The staff were observed to encourage residents' to choose the foods they liked and enjoyed at mealtimes.

Inspectors found that where residents' had specialised dietary requirements these were being met. For example, one resident had diabeties, and staff were familiar with residents needs. Another resident who was on a modified textured diet had clear guidelines from the speech and language therapist which the staff were familiar with.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Inspectors found residents' were protected by the designated centre's policies and procedures for medication management. Where improvements are identified they are actioned under Outcomes 14 and 18.

There was a medication management policy that guided staff practice. Since the last inspection, the respite service has been on hold temporarily. Therefore inspectors did not follow up on the actions relating to the policy at this time. This will be reviewed at the next inspection. An action relating to an unlocked fridge storing medications was not applicable at this time as no medications that required temperature controls were used in the centre.

Inspectors read a sample of completed prescription and administration records which were in line with best practice guidelines. However, one prescription sheet reviewed was not in line with the policy. For example, the maximum dose in a 24 hours period of "as required" (PRN) medications were not consistently prescribed. In addition, there was no space on the administration sheet to record the reasons for withholding medication. This was an action from the previous inspection and is actioned under Outcome 18.

The system of auditing medication audits required improvement. Inspectors reviewed medications audit of three houses that were carried out in October 2015. In one audit numerical scores were given on the findings. However, there was no action plan and nobody identified to follow up on any issues that had been identified. The other two audits were not fully completed. For example, there was no date, no score and no action plan. Staff at unit level told inspectors there had been audits but the findings were not

shared with them and copies of the audits had not been made available to them. This is discussed in Outcome 14.

There were procedures for reporting and investigating medication errors. An analysis of medication errors for 2014 was seen by inspectors. It findings state a high number of omissions had taken place. The report set out the action to take to prevent and reduce medication errors. For example, workload, communication with staff and human error. Medication errors were discussed with staff in one house and inspectors were informed errors had not occurred.

There was a policy in place to guide safe practice in residents' who choose to self medicate. There were no residents' self medicating in the centre. There were no medications that required strict controls used in the centre at the time of the inspection.

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

Findings:
The statement of purpose had been updated since the last inspection. However, it remained non compliant as it did not contain all information required by the Regulations or accurately reflect the centre.

The updated Statement of Purpose was dated October 2015. Overall, it contained most of the information required by the Regulations. However, it did not included fire precautions and procedures to follow in the event of an emergency. The occupational therapy and speech and language therapy services provided within the organisation were not reflected in the Statement of Purpose.

Inspectors found some information was not clear and concise. For example, the organisation structure was not centre specific or clear and which grade of staff had seniority in the houses at unit level.

A copy of the current statement of purpose was accessible to residents within each house in the centre.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors were satisfied that the person in charge was suitably qualified, experienced and full time in his role. This was an improvement from the last inspection, and fully addressed. He was present at the inspection on the second day, and fully participated in the inspection process and demonstrated appropriate knowledge of the Regulations. An interview had been held with the person in charge in the Authority offices in July 2015.

The residents were very familiar with the person in charge who was observed to spend time to talk and interact with them. The person in charge was responsible for two designated centres. In addition, he also carried out management duties in two other designated centres. There were two assistant managers who supported and deputised for the person in charge, but the rostering arrangements meant these persons were usually not scheduled to work on the same days and therefore all duties had to be carried out by the person in charge. Inspectors found this arrangement was not adequate and it was evident this was having a negative impact on the quality of the service as evidence in the report and outlined below.

The centre was operated by the Cheeverstown House Limited. There was a senior management team which included the provider nominee (manager of quality and strategic planning) who was new to the role since 2 November 2015. In addition, the director of services, assistant director of services and other heads of department within the organisation were on the team. However, within this management structure the lines of authority, accountability and responsibility for the provision of the service at centre level were not clear. Inspectors were not satisfied that the governance and management arrangements provided an adequate level of supervision of care and practice in order for the centre to be in full compliance with the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) with Disabilities) Regulations 2013. This was supported by the findings of this inspection,

with examples as follows:

- residents' files and information would not guide staff practice,
- healthcare plans were not developed for residents identified needs,
- fire safety deficits identified in the centre were not fully addressed,
- the management of risk was not effective,
- there was inadequate evidence of a systematic process for the on-going review of quality and safety in the centre,
- the centre was not adequately resourced at certain times of the day,
- staff were not formally supervised,
- staff meetings were not happening frequently or documented,
- person in charge not fully supported in his role.

Inspectors read reports of unannounced visits to two units in the centre. There were findings outlined however, there was no action plan or persons delegated to address the issues identified

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

Judgment:
Non Compliant - Major

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

Theme:
Use of Resources

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

Findings:
Inspectors found there were sufficient resources available to meet the needs of residents however, they were not deployed effectively throughout the centre to ensure there was autonomy within the houses.

Inspectors found resources were not effectively deployed in two houses to support resident's individual needs. For example, staff worked a shift pattern that ended at 9am in the morning - effectively when residents then left their homes to attend a day service or work. This meant there was no staff available in the homes if residents wished to remain there if they felt unwell or decided they liked a day at home. This was not in keeping with meeting the residents' assessed needs.

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

Findings:
Inspectors found there was experienced staff to meet the assessed needs of the residents at the time of the inspection. However, improvements were required in relation to staffing levels at times of the day in parts of the centre and supervision of staff.

The staff in the centre were qualified and there was a suitable skill mix to meet the needs of the residents. Inspectors found staff were knowledgeable of the residents' and their needs. They were friendly and patient with the residents' and had a good relationship with them and their families. Inspectors found staff were knowledgeable of policies and procedure which were available to them in the centre.

As reported in outcome 16, in two of the five units, staff were not rostered between 9am and 4pm when residents were at their day centres. While the person in charge said there was cover available, it could only be provided with sufficient advance notice, and as such the houses did not have the staffing levels for residents who wished to stay at home or were unable to attend day service, particularly residents of advanced age.

There was a planned roster read by inspectors. However, the rosters did not include the full names of persons, grade and if they were agency or relief staff. See outcome 18. This was discussed with the person in charge during the inspection.

There were no formal arrangements for one-on-one supervision meetings in the centre. This had been an action and the previous inspection was not addressed.

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

Inspectors read training records for the centre. The person in charge ensured all staff in the centre was provided with access to mandatory training including fire and protection of vulnerable adults. However, records read showed five staff had not completed training in the prevention of abuse in over two years, and two had not completed fire safety training in over one year.

The staff had also completed training in movement and handling of residents, first aid, CPR, and the safe administration of medication. In addition, some staff had completed training in eating and drinking training, epilepsy awareness and the administration of buccal midazolam.

A number of relief staff worked in the centre and there was evidence of regular training provided to these staff in all mandatory areas.

Judgment:
Non Compliant - Moderate

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

Theme:
Use of Information

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

Findings:
Inspectors found that there were systems in place to maintain complete and accurate records and the required policies were in place.

Inspectors found there were records required to be maintained for each resident. The maintenance of residents' files and accessibility of their information required improvement. Since the last inspection, the provider and person in charge had reviewed all files. A new system of documentation was being piloted within the organisation, of which drafts were seen by inspectors, and this work is acknowledged by the inspectors. However, further improvement was still required. There were between four and five folders for each resident that contained their personal information. Each folder

contained large volumes of information and as a result it was difficult to ascertain residents' most pertinent support and care needs. See Outcome 5.

Inspectors had reviewed policies and procedures at the previous inspection. The provider had ensured the designated centre all of the written operational policies as required by Schedule 5 of the Regulations. While all policies required by Regulations were in place improvements were identified. For example:there was no infection control policy. The finance policy did not reflect practice.

As reported in Outcome 17, there was a roster in place. However, the roster did not include staff names, grade, or if they were agency/relief staff.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004131
Date of Inspection:	03 and 04 November 2015
Date of response:	08 January 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents personal information was conspicuously displayed in communal areas.

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

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

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
• PIC and named house staff will review all information in each of the homes in this Designated Centre to ensure that any personal information is stored in personal files. The PIC, Provider Visit and Visitation template will capture this.
• Folders for EDS guidelines are kept in each kitchen with related information to guide practice.
• The minutes of staff and resident meetings will be held in separate books
• The agenda for the Resident meetings will include a review of the previous actions / issues to be addressed will start with immediate affect when the separate books are in place.
• A meeting will be held with residents to discuss where personal information should be displayed.

Proposed Timescale: 31/01/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Complaint records read did not included details of action taken, outcome and the satisfaction of the person making a complaint.

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

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

Proposed Timescale: 31/01/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The admission policy did not reflect admission practices.

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

Please state the actions you have taken or are planning to take:
Policy to be amended and updated to include the following:
• Resident and Next of kin involvement in initial house visit, decoration of room and option to stay over night.
• Consultation to take place with individuals living in the house.
• Transition plans should reflect policy changes above.

Proposed Timescale: 28/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The document did not clearly outline the additional fees which could be charged to the resident.

4. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
The memorandum of service provision will be individualised for the residents specific and unique requirements:
• What utilities are to be paid
• Which allied healthcare team / professional are included
• Potential additional charges which could be charged
• This will be led out by the Financial Controller, Management and PIC

Proposed Timescale: 28/02/2016

Theme: Effective Services

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

The document was not signed by a representative of Cheeverstown House Limited.

5. Action Required:
Under Regulation 24 (2) you are required to: Provide each prospective resident and his or her family or representative with an opportunity to visit the designated centre, insofar as is reasonably practicable, before admission of the prospective resident to the designated centre.

Please state the actions you have taken or are planning to take:
Memorandums to be signed by the PIC, Residents or Representative

Proposed Timescale: 28/02/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no multidisciplinary input in the review of residents personal plans

6. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
Revised Personal Plans will be implemented which reflect plans of care including risk assessment forms and MDT input.

Proposed Timescale: 28/02/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Health care plans were not developed for residents identified health care needs.

7. 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:
• Healthcare Plans have been included in the revised personal plans which are being piloted in 3 designated centres including this designated centre. This pilot commenced the 1st of October.
• The SIT (service improvement team) and Quality dept. and relevant healthcare

professional have informed the development of Personal care plans which includes a comprehensive assessment of an individual's care needs and from this the development of a plan of care which will guide practice.
• The development of these care plans will be facilitated and signed off by identified healthcare professionals.
• Implementation of Revised Personal Care plans will be in place within this designated centre with the support of the identified planned coordinators.
• The PIC and the planned coordinator for this designated centre will complete the implementation of the healthcare plans commencing the 14th of December.
• These plans will be reviewed at a minimum of 3 months and rewritten every 12 months by the identified house lead.

Proposed Timescale: 28/02/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The reviews of residents personal plans did not include if they were effective or not.

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

Please state the actions you have taken or are planning to take:
• Standard Operating Procedure on Compiling, Maintaining and reviewing a personal plan will be implemented.
• This identifies a time frame of 6 monthly reviews including actions completed and auditing of personal plan annually by Plan Coordinators / Managers / PIC
• Data on the effectiveness and whether goals are achieved under individual plans are inputted on the Quality database and accessible by all managers.
• From the 14th of December the Quality co-ordinators will be training and supporting the implementation of the personal plans in this designated area.
• Personal Outcome Measures training will be delivered to new staff on the 15th and 16th of December.

Proposed Timescale: 28/02/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy was not implemented in practice as there was no system of identifying and assessing risks in each unit.

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

Please state the actions you have taken or are planning to take:
• Each house in this designated centre will have a local Risk register (capturing health / safety / environmental risks).
• Risk policy to be reviewed and implemented.
• Training to be put in place for all staff in this designated centre.
• Risk assessment training commencing on the 18th of December for the staff associated with a resident living within one of the houses in this designated centre.
• Risk Assessment training has now been delivered across the organisation to over 100 staff and will be fully implemented by (30th April 2016)
• Risk register files are now printed and ready for each house in each designated centre. Completed (7/12/2015)
• Risk registers Excel spreadsheets for each house in each designated centre are now set up in a shared folder on the server accessible to all Persons in Charge. Completed (7/12/2015)
• Persons in Charge/PPIM will populate these risk registers and commence regular audit of health & safety environmental risks and summaries of serious individual risks in each location. Risk registers will be discussed with staff at all house meetings to ensure risk assessments and support plans are reviewed by their due date. This process to be fully implemented by (29th February 2016)
• Risk registers will be audited during unannounced Provider/Senior Manager visits commencing from (29th February 2016)

Proposed Timescale: 31/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were deficits in the fire doors provided in the centre.

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

Please state the actions you have taken or are planning to take:
Fire door installation: Program of works to be completed by end of January 2016.

Proposed Timescale: 31/01/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose did not include the fire and emergency procedures for the centre.

11. 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 fire and emergency procedures for the centre will be included in the statement of purpose.

Proposed Timescale: 08/01/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Aspects of the Statement of Purpose were not clear for example, the organisational chart and allied health service.

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

Please state the actions you have taken or are planning to take:
A current review of the organisational structure commenced on 30/11/15. The review plans to identify the following:
• A social care leader across each of the houses in the designated centre to ensure accountability at house level and devolvement of accountability from PIC to house level.
• In the restructuring process there will be a SCL leader responsible for each house in this DC.
• This restructuring will support the staff in each house and the residents to improve systems of supports.
• The PPIM's assigned this DC will support the SCL and house team to improve systems of support and implement new processes.
• This revised organisational structure will be updated in the statement of purpose.
• In the interim The PIC will identify one lead staff on the roster in each house that will be accountable at a house level. This staff will report to the Clinical Nurse Manager 2 / PPIM and PIC. This will be reflected in the statement of purpose.
• Rosters will reflect this change on the 28/ 12/16.

• Allied Health Service: The statement of purpose will be reviewed to indicate allied health services. The statement of purpose will reflect the following:

· It will identify the health care professionals involved in the designated centre.
· Under Admissions within the Statement of purpose the assessment of need will identify the Multidisciplinary input.
· Under "Individual personal plan" within the statement of purpose the health care plans will be reflected and the process in place i.e. review, sign off of assessment of needs in health care plans which will be completed by health care professional.
· This will be completed by Quality manager ad PIC for the designated centre and in conjunction with health care professionals.

Proposed Timescale: 01/02/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system of reviewing the safety and quality of care in the centre required improvement. For example, reports read did not include actions or improvements to be brought about and overall learning.

13. 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:
• All provider and PIC visits / meetings will be documented with an action, time frame and nominated individual identified.
• Findings from the nominated provider visits are communicated back to the PIC at the PIC Provider meetings.
• Any maintenance issues identified on the provider visits are referred directly by email to the Operations manager and PIC for the designated centre.
• A copy of the report is placed in the meeting book in each of the houses for discussion at the staff meeting.
• A meeting to be held on the 11th of January were a report will be circulated which will summarise the findings of the Provider Visits and actions required. The PIC for each designated centre will identify a person responsible to complete the action and provide a time frame. This will be reviewed at the PIC / Provider meeting.
• Actions arising from the provider visits are placed on the agenda for the property committee which meets monthly and the quarterly Health and Safety committee meeting.
• Health and Safety representatives and catering / housekeeping to complete visits to the designated centre in relation to health and safety and quality of the environments.

This will be documented and reported into the PIC/Provider visits.

Proposed Timescale: 01/01/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The roles and responsibilities of persons involved in the management of the centre were not clear and required clarification.

The systems in place to support the person in charge to manage two designated centres required review.

14. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
• CNM2 will return to support the PIC in this DC from the 28th of December 2015.
• A team lead will be identified in each house in this DC which will take over the local responsibilities and will be identified in the roster from the 28th of December.
• The PIC in this designated centre is also the manager across four other designated centres. The manager in collaboration with the Director of Service and Assistant Director of service will review the PIC responsibilities across the 4 designated centres and assign responsibilities to each PIC to allow for protected time for the duties to be carried out for example one to one supervision of staff, house visits. Action to be completed by the 28th of December which will be reflected in the next roster.
• A review has commenced (30/11/16) to map out a management model, staff rostering and driven by assessed need.
• This restructuring group will be meeting weekly and have identified pilot sites to commence implementation.
• In line with the objective for this restructuring group the PIC from this designated centred has already reviewed the existing structure and identified areas of need in relation to governance and accountability. The implementation of this will be in collaboration with Finance, HR, Frontline Staff, Management and Unions. This structure will include the roles and function of each staff member.
• Meetings are documented with specific actions carried over each week. This will continue to take place weekly.

Proposed Timescale: 01/06/2016

Theme: Leadership, Governance and Management

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

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

15. 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 Annual Review of Safety and Quality of Care report will be completed by the nominated provider in conjunction with the PIC in this designated centre.
This report will include information collated on the Quality database and key committees within the organisation. The data will relate to key safeguarding and assurance areas these include:
• Risk
• Health and Safety
• Health and Wellbeing
• Complaints
• Personal Plans
• Positive Supports
• Rights / Restrictions / Restraints
• Social / community inclusion

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

Proposed Timescale: 31/01/2016

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Resources were not deployed within the service to ensure adequate staffing at times of the day and that the centres were managed at unit level.

16. 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 community utilise a bank of resource hours to facilitate people who are sick, have appointments or require respite.

• Presently if a resident is unwell the scheduled staff already in place will remain until a

staff from the organisations relief panel or an agency employee is scheduled to work.

• In addition those residents attending day services are currently accommodated to go to appointments or go home early.

• The management team are reviewing staffing for this designated centre which will align rostering with the identified needs of the residents and reflect daytime coverage as part of this review. This commenced on 3/12/16.

Proposed Timescale: 01/05/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staffing levels during the day from Monday to Friday in the units required review.

17. 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:
We will develop a roster to reflect:
• The staffing requirements to meet assessed needs of the residents
• Identify the qualifications and skill mix of the staff
• Be reflective of the statement of purpose
• A weekly governance review has commenced which consists of the SIT team representative, Director of Service and CEO to review management cover and to ensure governance as per HIQA requirements. This includes appropriate PIC coverage across all designated areas and reviewing staff rosters to ensure needs are met.

Proposed Timescale: 01/03/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The was no system of supervision of staff in the centre.

18. 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 line of accountability (including roles and responsibilities) from PIC down will be identified in each house in this designated centre. This will also include a one to one supervision.
• Through the performance management system each (number of staff) staff will receive one to one supervision.
• An annual performance review will be completed with all staff members

Proposed Timescale: 31/01/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were gaps in the refresher training completed by staff in fire safety and prevention of abuse.

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

Please state the actions you have taken or are planning to take:
• The PIC in collaboration with HR and training will identify those staff who have not completed mandatory training and ensure staff schedule themselves for training at the nearest available.
• The PIC in conjunction with the HR department will identify gaps in training and incorporate more robust monitoring training deficits.
• PIC and management will identify expiry dates for training and flag in advance to staff.

Proposed Timescale: 01/02/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The finance policy required review.

There was no infection control policy.

20. 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:
• Infection control policy is now complete and is awaiting sign off by the Board.
• Review completed on Prevention of Abuse Policies clarified that it is compliant with the National Policy on the Safeguarding of vulnerable adults.
• The financial policy has been reviewed and amended and awaiting sign off by the Board as per process.

Proposed Timescale: 31/01/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in the information required to be included in the staff roster.

21. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
Rosters will include full names of persons, grade and if they were agency or relief staff. A new template has been circulated to capture this information.

Proposed Timescale: 28/12/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents records were not easily accessible as their information was held in up to five folders with large volumes of information.

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

Please state the actions you have taken or are planning to take:
New revised Personal Plans will consist of one comprehensive plan with a second folder having supporting documentation relevant to that calendar year.

Proposed Timescale: 01/03/2016