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-0004927
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House Limited
Provider Nominee:	Paula O'Reilly
Lead inspector:	Deirdre Byrne
Support inspector(s):	Gearoid Harrahill
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
10 November 2015 09:00	10 November 2015 18:00
11 November 2015 08:30	11 November 2015 15:00

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 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The Health Information and Quality Authority's (the Authority) unannounced inspection was undertaken to assess compliance with the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards of Residential Services for Children and Adults with Disabilities. Inspectors also followed up on 25 actions required from the previous inspection carried out on the 21 and 22 June 2015. The non compliances were discussed with the provider nominee at a number of meetings in the Authority offices following the inspection.

The Authority carried out inspections of four designated centres in the organisation on the same day. This report relates to the inspection of one of those centres: centre number OSV 4927.

There are 19 residents living in the centre. Each resident has an intellectual disability. The centre forms part of a larger residential campus and consists of four units (to be called houses in the report). During this inspection, inspectors met with residents', staff members and management staff. Inspectors met with the new nominated provider and discussed the response to the above proposal and to review implementation of the proposed actions. One resident was in hospital and some of the residents' were at various activities and day services, therefore not all of the residents' met with inspectors.

Inspectors found that a new person in charge had been appointed and some of the actions from the previous inspection had been completed, while others had been progressed, there were still significant improvements required. Inspectors did review evidence of action plans that had been developed to address areas for improvement and recognise that this is a work in progress. The governance and management outcome had a major non compliance. There was no report on the safety and quality of care provided to residents' and unannounced visits to the centre by management did not generate action plans to support service improvements.

Overall, inspectors found that there was significant progress made since previous inspection. A new person in charge had been nominated to oversee the service. The quality of residents' lives had been improved by the relocation of residents to more suitable accommodation that met their assessed needs. A service improvement team had been set up to drive change and improvement across the organisation and the centre.

The premises and documentation were viewed and examined by inspectors and care practices were observed. The residents', many of whom required a degree of support and assistance with their activities of daily living had benefited from changes which enhanced their quality of life. Incidents of alleged peer abuse had decreased and inspectors were informed that a number of residents', who were non compatible, were now living in separate settings. In addition, training for staff had focused on understanding the reason for the behaviours and on promoting de-escalation techniques. Inspectors found the privacy and dignity of residents living in the centre had significantly improved. All twin bedrooms, with the exception of one, had been reduced to single occupancy bedrooms.

There were systems in place to safeguard and protect residents from abuse, with a designated person assigned responsibility in this area. However, training for staff and timelines for investigations required improvement. There were good practices to support residents with responsive behaviours and also to transition within the service and into the community. Residents had a range of interesting things to do during the day, although these were mainly based in the campus itself. Residents' information was available and maintained in their homes however the overall documentation, development and review of residents' personal plans required review. Due to the size and layout of residents' files, information was not easily accessible.

There was a person in charge of the centre nominated since June 2015. He attended a fit person meeting in the Authority offices in July 2015 and demonstrated adequate

knowledge of the Regulations. However, improvements were required to ensure effective governance at centre level as the person in charge also oversaw another designated centre, and could be called on to cover the management of two other designated centres on the campus and four in the community. Inspectors found staff meetings were taking place, though a formal system of staff supervision had yet to be put in place.

The monitoring of the quality of care provided in the centre also required improvement and there was no annual review of the safety and quality of care provided to residents' in the centre carried out. These matters were discussed with the senior management at the end of the inspection and at the feedback meeting. They assured inspectors these issues would be reviewed and measures taken to address them.

There were 25 actions from the previous inspection reviewed. 14 actions were completed, 2 were in progress and 9 were not addressed.

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 residents' rights were respected. However, improvements were required in relation to the management of complaints, maintaining residents' privacy and consultation with them regarding how their home was run.

The centre was managed by staff however, there was no evidence of residents being consulted with in how their home was ran. There were no regular house meetings taking place in any of the houses. Staff told inspectors they consulted with residents about their food choices after completing the weekly house shop each week however, there was no written evidence of this consultation.

Inspectors saw staff notices and information pertaining to them was displayed in communal rooms of the houses although there was a staff office in each of the houses where this information could be stored.

The centre had information including contact details of the National Advocacy Committee on display in the houses together with lots of information about residents' rights. There was also an internal advocacy representative and his photo and dates of upcoming meetings were display in each house.

Inspectors were informed that the campus served as a polling station during elections and residents could vote. However, staff were unsure which residents' had the capacity or were registered to vote.

The centre was located close to a number of churches of different religious

denominations which residents' could access. Residents' were facilitated by staff to attend if they wished. Roman Catholic mass was also held in the campus every few weeks.

Staff respected residents' privacy and dignity, and were observed to talk to residents' in a patient, friendly and respectful manner.

There was a policy on the management of complaints and a copy was on display in each of the houses. This was an improvement from the last inspection. However, the policy did not reflect the practice or legislative requirements. For example, the person nominated to deal with complaints in each house, the appeals person or the person responsible for reviewing complaints were not identified.

There was a complaints officer for the organisation and inspectors were told staff dealt with complaints and unresolved complaints would then be escalated to the complaints officer. There were no complaints in any of the houses. The complaint record forms were not available in the houses but held in the managers office.

There were policies and procedures on the management of residents finances and systems were in place to support residents to manage their day to day monies. A sample 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. In addition, there were audits carried out by the management team and finance departments.

The centre was in the process of ensuring that each resident had their own bank account. Inspectors discussed this with the finance team. They explained that a bank account had been set up for each resident. Each resident had an automatic transaction machine card and these would be distributed once the lodgement of pensions or disability allowances into their bank accounts had been formalised. Additional procedures and auditing of staff practices by the finance team were outlined to inspectors.

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 residents' communication needs.

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 residents required. Residents had their communication needs assessed on admission. The assessments were detailed and reflected the residents communication needs. Residents identified 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 communicated well with residents they understood their individual ways of communicating. Residents appeared confident in making themselves understood.

Residents had access to portable house telephones, televisions and radio. There was access to wireless internet in the centre, this was an improvement from the last inspection. Inspectors were informed portable devices were available for residents who wished to access the internet.

Information on display in the houses was not always available in a format that could be understood by all residents. For example, some were displayed too high for wheelchair dependent residents to read, the font was too small for some residents to read and for those with little literacy skills there were no pictures or easy read format that would support these residents to understand.

Judgment:
Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
The admission policy and contract of care had both been reviewed and rolled out to all residents since the last inspection however, both required further review.

The admission policy had been reviewed in March 2015. On reading inspectors found it did not reflect the inclusive admission and transfer process practiced in the centre. For

example, it did not state that future residents' or their representatives were invited to visit the house, meet the current residents', to stay overnight and were involved in the re-decoration of their personal space prior to their admission.

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

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors found 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 was good practice in relation to access and the provision of opportunities to participate in meaningful activities appropriate to residents' interests.

Staff were familiar with the residents' social care needs. The residents' living in the houses all required staff support and assistance, as each had an intellectual and/or physical disability. Inspectors reviewed the personal plans of two residents'.

The personal plans for residents' social care needs were called ''personal outcome measures'' (POMs). A POM assessment was completed by residents' key worker in consultation with the resident. A sample of completed personal plans reviewed were holistic and focused on a varied aspect of the resident's life, such as meeting their

friends more frequently. There were monthly evaluations of the residents' goals however, these were incomplete or limited to discussing one goal. In addition, there was no evidence of multi-disciplinary input, resident involvement in the review and if the residents goals were achieved. The completed POMS were not available an accessible format for residents' to understand. These issues were identified at the last inspection and were not completed. At the last inspection new personal plan documentation was seen by inspectors but it was not yet rolled in all houses of the centre.

Residents' had detailed assessments completed where healthcare needs were identified. However, the healthcare action plans developed lacked detail to guide staff for example, risk of falls, eating and drinking guidelines, weight loss, and long term health conditions (see Outcome 11). In addition, intimate care plans did not reflect residents wishes and preferences. This was an issue at the previous inspection also.

Inspectors found residents' records were contained within four to five large folders therefore, it was difficult to identify the most up-to-date information on each resident. This is discussed further under Outcome 18.

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' attended a number of activities or day services (both internal and external to the service). Some residents' had personal assistants who provided 1:1 care a number of days each week. Inspectors read information on display in the houses about the activities available to the residents, including an onsite disco. One resident was supported to go on an outing with a relative during the inspection. Staff and the resident told inspectors how the resident looked forward to seeing their relative and enjoyed the outings very much. However, the activities accessible were mainly available on the campus hence, they had little or no opportunities to link in with the local community. In addition, activities available were not suitable for all residents' assessed needs and interests and as a result not all residents' could attend, for example, due to age, mobility or dependency.

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

Findings:
Inspectors found the design and layout of the designated centre now met the individual needs of the residents'. There are four houses in the centre, and three were visited. The majority of the actions from the previous inspection were addressed. There was one area of improvement identified.

House 1

This is a two storey house. There was presently one resident living in the house. Inspectors did not meet the resident as they were presently in hospital. However, senior management and staff provided an update for inspectors. Since the last inspection, a resident who had mobility issues had transitioned into a new house in the community. The new house was suitable for the resident's assessed needs. The two residents who shared a twin bedroom had also moved into more suitable accommodation that met their assessed needs. This was an improvement from the last inspection. Inspectors were informed that these residents were very happy in their new homes and the transition had a very positive impact on them.

House 2,3 and 4:

These three bungalows were visited by inspectors. The issues identified at the previous inspection in two of the houses were followed up. They related to the two bedded bedrooms not fully meeting the residents' needs to ensure their privacy and dignity was being met. Since the last inspection, all two bedded bedrooms had been reduced to single occupancy. There was one two bedded room remaining in one house. Inspectors were informed that as soon as a vacancy arose in the centre, one of the residents' would be offered to move there. The goal was for all residents' have their own bedroom in the centre. In the meantime screens were provided between the two beds to ensure the present residents' privacy was maintained.

The bedrooms visited by inspectors were decorated in accordance with the wishes of the individual resident and contained personal items such as television, family photographs, posters and various other belongings.

There were an appropriate numbers of bathrooms, showers and toilets in the centre to meet the residents' needs. However, inspectors found these rooms were not very homely or decorated to a good standard.

There were separate laundry facilities provided. Inspectors met cleaning staff employed to carry out the cleaning procedures. There was suitable cleaning equipment provided.

A garden was directly accessible from each house. The action from the previous inspection was not reviewed at this inspection, and will be followed up at future inspections.

Judgment:
Substantially 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 fully addressed. Five draft risk registers had been developed for houses in the campus. These were seen by inspectors. It was planned that once the risk registers were developed for all houses, 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 reports of the audits were read by inspectors and they included a range of health and safety checks including maintenance and fire safety. Where issues were identified such as maintenance risks, these would be brought to the attention of the properties manager who would action improvements or change.

There were systems in place to report and respond to incidents in the centre however, these required improvement. A risk assessment form was completed by staff who risk rated the incident. The forms were then sent to the person in charge for review who in turn sent it to senior management. Inspectors were informed by senior management that the information in the forms was collated and analysed. The information and reports generated from same provided clear incident numbers and trends arising for individual residents and within each unit of the designated centre, for example, times and notes from escalated behaviours identifying triggers and times of higher risk. However, this information or individual follow up action was not clearly communicated with staff at centre level and incident forms were not consistently returned. Therefore it could not be ascertained what change had been brought about and learning for staff. This was an action at the previous inspection and required improvement.

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. Furthermore, some practices at local level were not adequate for example, the use of disposable sponges.

There was an organisation wide emergency plan and staff were familiar with them. Each resident had an individualised evacuation plan developed. Inspectors read one plan that stated the resident required the support of two staff to mobilise from bed into a wheelchair, although there was only one staff based in the house at night time. However, since the last inspection, an additional two floating staff were available at night time to support the night manager. This arrangement would ensure the staff in the house would receive support if an evacuation was required.

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 (see Outcome 17). 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. The drills were reviewed at the health and safety meetings.

There was evidence that fire equipment was serviced regularly, as confirmed by the service records read of the servicing of the fire extinguishers, fire alarms and emergency lighting. 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 had been installed in one house in the centre. However, fire doors were not yet installed in three houses. A list of the areas where deficits were identified was forwarded by management after the inspection. Inspectors were assured by senior management that these works were being prioritised and will be completed by March 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. However, the systems in place to investigate allegations of abuse and the policy on the prevention of abuse required review.

There was a policy on safeguarding residents from abuse which contained guidelines on how any allegations of abuse would be managed. The provider nominee also submitted an update following the inspection that confirmed the policy referenced the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. However, the centre's policy did not fully guide practice. For example, the role of the person in charge was not clearly described or the person who was responsible for notifying allegations of abuse and submitting follow up actions to the Authority. A draft procedure was later shown to inspectors which was expected to clarify this. This is discussed in Outcome 18.

Inspectors did not meet the person in charge or managers deputising for the person in charge as they were on leave. A nurse manager was covering the management of the centre in their absence. She was familiar with the types of abuse and the internal reporting arrangements in place. However, as outlined in the paragraph above, the responsibilities of the managers were not so clear.

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.

There was evidence since the last inspection that incidents of allegations of abuse were investigated and managed in accordance with the centres policy. However, the timelines for completing investigations required review, as there were gaps of a number of months between incidents occurring and investigations being completed. This was discussed with senior management during the inspection.

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, up to half of the staff in the centre had not completed refresher training, this is discussed under Outcome 17.

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. However, from a sample read these would not fully guide practice. For example, reports were read where one resident would become were upset when unfamiliar staff carried out personal care and yet their concerns was not reflected in the care plan. Furthermore, there were two versions of the resident's intimate care plan on their file. See Outcome 5 and 17.

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 general practitioner (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.

There were systems in place to support residents with their responsive behaviours. A positive support plan was developed where required. The support plans guided staff practice on how to manage the behaviours. Residents' also had communication passports and where required, these included the behaviour support plans in place to a resident with identified behaviours that challenge.

There was very little use of restrictive practices in use in the centre. These were limited to bedrails and lap belts. Inspectors read risk assessments, and there were regular monitoring checks carried out by the staff when a restriction was 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:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
Inspectors found that residents' healthcare needs were generally being met. However, improvement was needed in relation to the systems in place, including documentation, to ensure that residents' healthcare needs were regularly reviewed, and care records updated if their needs changed. This is referenced and the related action plan is under Outcome 5 (social care needs).

While reviewing residents' records and speaking to the staff it was clear that where residents' had healthcare needs they were identified, and appropriate action was taken. For example, records showed if residents' were expressing when they were in pain, then it was recorded that they had seen the GP and received appropriate treatment. Where residents' were not able to say they were in pain, inspectors saw there was guidance for

staff about how residents' may communicate pain in other ways. On the day of the inspection, staff were seen to be taking action where it was identified a resident was feeling unwell.

Some residents' had long term healthcare needs and records showed staff had created links with the health professionals both within the service, and external specialists. For example some residents' had contact with consultants from local hospitals. The letters, healthcare instructions and notes recorded on files showed residents' were having appointments scheduled and feedback was being given following the meetings.

Records showed residents' had access to a GP, including an out of hour's service. Within the service there was an occupational therapist, physiotherapist, psychologist, social worker and psychiatrist. Residents' were supported to access other professionals from the community such as chiropodists, opticians and ophthalmologists.

In each of the houses residents' had a range of healthcare needs, and systems, including completed documents to monitor their healthcare specifically in relation to those needs. For example weight monitoring, records of seizures, and use of 'as required' medication, PRN. There were also a number of protocols in place to describe how care was to be provided in certain cases, for example if a resident had an epileptic seizure and needed rescue medication.

There was a record of medical appointments for each resident, and also information about when next appointments were due, however, there were two versions of the same document in different files for one resident. There could be a risk of missing appointments as a result.

Inspector reviewed a selection of residents' personal files and it was identified that all residents' had 'My Health Plan' in place that gave an overview of their health care needs. However, for some residents' it had been written in 2013, also it was not clear when additional information was added as it was not signed or dated. This meant that there was no comprehensive document that set out the residents' current healthcare needs and it was not possible to see if needs were being reviewed and appropriate treatment provided. This action remains outstanding from the last inspection. The action for this is made under outcome 5

While the health action plan provided some guidance to support staff improvements were required. For example, specific health care issues, eating and swallowing guidelines and falls prevention measures lacked sufficient detail in one resident's file reviewed. This action is also made under outcome 5.

Inspectors observed breakfast being served during the inspection. The residents' did not require any assistance, and they received encouragement during the meal by staff who sat beside them. Some residents' were involved in cooking and choosing their menu, in other houses the residents' were supported by the staff to make meal choices.

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

Judgment:
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):
No actions were required from the previous inspection.

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

Inspectors reviewed a sample of prescription and administration records and saw that they complied with good practice, medication was individually prescribed and good practice was observed in providing residents alternative forms of medication where necessary. Secure fridges were provided for medications that required specific temperature control.

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

There was evidence of medication audits taking place, however staff were not fully aware of the findings and improvements required. This is discussed in Outcome 14 (Governance).

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 September 2015. Overall, it contained most of the information required by the Regulations. However, some information was not clear and concise. For example, the organisation structure was not centre specific, which grade of staff had seniority in the houses at unit level was not stated, the complaint procedures did not reflect practice in the centre, and it did not include details of the nurses manager who deputised for the person in charge. Not all nurse managers who support and deputise for the person in charge were reflected in the document.

A copy of the current statement of purpose was not 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:
There was a person in charge nominated since the last inspection. 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. An interview had been held with the person in charge in the Authority offices in July 2015 during which he demonstrated knowledge of the Regulations and his responsibilities therein. The person in charge was on leave during the inspection.

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

adequate. A nurse manager was deputising in the absence of the person in charge as other managers of the centre were on leave. The nurse manager was overseeing two designated centres, but was also responsible for another two designated centres on the morning of the first day of the inspection. Inspectors did not observe the manager in the houses, or meeting staff and residents'. Later in the inspection, this person spoke to inspectors and outlined her role and responsibilities. She primarily oversaw the completion of the rosters for the two designated centres and arranging cover for unexpected leave. This took up the majority of her time. 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 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 also 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 did not guide staff on how to meet residents identified needs,
- fire safety deficits identified in the centre were not fully addressed,
- the management of risk was not effective,
- the ongoing review of quality and safety in the centre was not used for learning or shared with staff,
- one house was not adequately resourced at night time,
- staff were not formally supervised,
- managers overseeing the centre were not fully supported in their role,
- there was no lines of authority clarified at unit level in the centre

Inspectors read reports of unannounced visits to one house in the centre. The findings were outlined however, the action plan did not consistently address the findings and persons were not delegated to address the issues identified. This was discussed with the provider who assured inspectors the findings were discussed in detail at person in charge meetings and the documentation of the reports would be reviewed to contain more detail. It was expected to complete unannounced visits of all units in the centre before the end of the year.

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

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

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

The provider nominee had appropriate contingency plans in place to manage any such absence. There were three nurse managers available to cover absences of the person in charge. These persons were all on leave during the inspection. A nurse manager was deputising in these persons absence during the inspection.

Judgment:
Compliant

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

Theme:
Use of Resources

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

Findings:
Inspectors found there was sufficient staff on duty to meet the residents' needs however, insufficient resources had been provided at times to meet the needs of residents'.

The action from the previous inspection was reviewed and it was found to be completed as sufficient staff resources were in place during the day. However, at night time in one house, there were insufficient resources to ensure residents' assessed needs were met.

For example, one resident was assessed as a high risk of falls, and required assistance from staff to mobilise and transfer between bed to chair to toilet. There was one sleeping staff rostered but no waking staff. While there were floating night staff who work over the campus to support, reports were read that the night floating staff were finding it difficult to assist the resident at all times. Inspectors discussed this with nurse managers who explained that the resident had been offered to move to a house where waking staff worked, but they had declined as they wished to remain in their home. The resident continues to live in the house with no additional resources made available.

This was discussed with staff, and senior management at feedback.

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 were 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 the supervision of staff.

The staff in the centre were appropriately qualified and there was a suitable skill mix to meet the needs of the residents'. 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 procedures which were available to them in the centre.

In general, there were adequate staffing levels in the centre. However, an area of improvement was identified at night time in one house. The details and related action plan are under outcome 16,

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. In

addition, the person in charge and management were not included in the roster. Staff did not know who to report to until a manager called their house to inform them.

There were no formal arrangements for one-on-one supervision meetings in the centre. This 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 at future inspections. A service level agreement reviewed at the previous inspection that gave assurance of the qualification and vetting of agency staff.

Inspectors read training records for the centre. The human resources team showed inspectors a detailed programme of scheduled staff training completed to date in 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 that not all staff had received training in the prevention of abuse and 5 had not completed fire safety training in over one year.

The staff had also completed training in the movement and handling of residents', first aid, cardio-pulmonary resuscitation (CPR), and the safe administration of medication. In addition, some staff had completed eating and drinking training, infection control and epilepsy awareness.

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

Judgment:
Non Compliant - Moderate

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

Theme:
Use of Information

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

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

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

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

As reported in Outcome 17, there was a staff roster in place. However, the roster did not include staff names, grade, and the person in charge or management were not included.

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:

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 report[1]

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House Limited
Centre ID:	OSV-0004927
Date of Inspection:	10 and 11 November 2015
Date of response:	05 February 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not been consulted with about how their home was being managed.

1. Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability,

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

participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
• Consultation will take place on a weekly basis with residents which will be documented to demonstrate how residents have been consulted in relation to meal options, daily routines and activities in the home. This will be completed by the house lead and keyworker for each of the residents.

• This consultation will be reflected in weekly meal planners, shopping list for the residents and in activity sheets for each resident.

Proposed Timescale: 28/02/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not clearly identify the person nominated to deal with complaints at local level, the appeals person and the person nominated to oversee complaints.

2. Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

Please state the actions you have taken or are planning to take:
• The accessible complaint procedure will be updated to ensure it clearly identifies the nominated person at local level, who is the appeals person and the person who will oversee complaints.
• Complaints procedure will be updated by Dec 14th. Communication and implementation of the new procedure and accessible documentation will commence in DC4 Jan 22nd 2016.

Proposed Timescale: 22/01/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not supported at all times to communicate in accordance with their needs.

3. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
• The residents have communication matrix's completed with their level of communication support needs identified. These will be reviewed with each staff member so ensure their understanding of how the resident should be supported around communication.
• All communications for residents to be reviewed and made accessible based on assessed need.
• Those with limited literacy skills require easy to read or pictorial format.
• To be completed by manager and keyworkers in each of the houses.

Proposed Timescale: 28/02/2016

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.

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

Please state the actions you have taken or are planning to take:
• Resident and Next of kin involvement in initial house visit, decoration of room and option to stay overnight.
• Consultation to take place with individuals living in the house.
• Transition plans should reflect policy changes above.
• As per the de congregate settings report there will be no admissions to the residential houses on campus however transfers may occurs within the campus to reduce numbers.

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 was not agreed/signed by a representative from the organisation.

5. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each

resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

Proposed Timescale: 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 services and facilities included in the monthly fee.

The document did not clearly outline the additional fees which could be charged to the resident.

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

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

Proposed Timescale: 30/03/2016

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

7. 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:
• We have developed a system were the MDT input is identified in the Standard Operating Procedure for the "Compiling, Maintaining and Reviewing a Personal Plan".
• The key staff working with the resident will ensure that this is included in the personal plan. The PIC and planned coordinators will be required to review personal plans as needed or at a minimum of 6 months to ensure this MDT input are captured.
• The revised Personal Plans being implemented will include plans of care involving MDT input and be documented in the personal care plans and signed off.
• At present the MDT input for residents is captured on the quality database. This database collates information based on each resident in the designated centre in the following areas:
Mental health and ID
Positive Supports
Communication
Complex needs
• All PICs have access to this database to inform them of those individuals receiving MDT support services.
• A meeting was held with all PIC's and managers on the 23/11/15 to communicate that collaboration with the MDT is required when reviewing personal plans and to document same (evidenced in minutes of meeting).
• A date is being confirmed to meet with all clinicians to discuss their role in the review process, signing off and attendance at planning meets for residents.
• Clinicians are also updating all information on the quality database for PICs to access.

Proposed Timescale: 31/03/2016

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 and evaluation of the effectiveness of the plan..

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

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

• It will commence in this designated centre in January 2016.

Proposed Timescale: 01/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In some cases personal plans lacked sufficient detail in relation healthcare needs to guide staff.

9. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
• 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.
• This assessment includes Falls, Eating, drinking & Swallowing.
• 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.
• Each resident's intimate personal care plan will be reviewed to reflect their wishes and preferences related to personal and intimate care.

Proposed Timescale: 30/03/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents health, personal and social needs had been reviewed to reflect their changing needs

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

Please state the actions you have taken or are planning to take:
• Review suitability of residents activities i.e. age appropriate, mobility level and level of dependency.
• Review as part of the personal Outcome measure Plan in relation to inclusive environments opportunities for residents to engage on a regular basis in activities of their choice in the community.
• Residents identified as having personal assistants should reflect how these resources are being used to connect the person to the community.
• Evidence of these activities need to be documented by the keyworker and reviewed by the PIC to ensure that they are carried out consistently and in a format which is accessible to the individual.

Proposed Timescale: 30/03/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Toilets and bathrooms in the centre were not very homely or decorated to a good standard. .

11. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
Review the bathroom / toilets in consultation with the residents and the PIC to improve the environment to reflect a more home like environment.
• Consultation with residents has commenced in all houses regarding redecoration of bathrooms.
• This will include residents choosing paint colours for all bathrooms (currently white), colourful shower curtains, blinds and accessories for the bathroom based on resident's preference.
• Work has commenced with staff and painters in one residential house.

Proposed Timescale: 30/03/2016

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

for identifying and assessing risks in each unit.

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

Please state the actions you have taken or are planning to take:
• Each house in this designated centre will have a local Risk register (capturing health / safety / environmental risks).
• Risk policy to be reviewed and implemented.
• Training to be organised with HR and Assistant Director of Service for this designated centre.
• 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: 01/03/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of follow up action to be taken or learning for staff when incidents occur in the centre.

13. 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:
• Any serious risk incident or adverse event scored ≥ 9 requires a new or reviewed risk assessment to be completed and appropriate support or control measures planned to minimise the likelihood of reoccurrence or to reduce the impact of a reoccurrence
• These serious risk incidents or adverse events and supports/control measures will be identified in the person's Individual Safety Plan
• The house Service & Care provision and Health & Safety Risk Register is a summary of the serious risk incidents and adverse events identified and their supports/control

measures used as an audit tool
• Local Managers and frontline staff refer to the house Service & Care provision and Health & Safety Risk Register as a set agenda item at every house staff meeting and discuss and review the learning from the identified risks and supports/control measures
• The house Service & Care provision and Health & Safety Risk Register is audited during unannounced Provider/Senior Management visits
• Risk is discussed as a set agenda item at Provider/PIC meetings

Proposed Timescale: 30/03/2016

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.

14. 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:
• First doors are completed in one of the residential houses in this DC.
• Work has commenced and will be completed end of February in one of the residential houses and the remaining doors will be completed by the end of March – Mid April (this is due to constructional work needed to the door frames to allow installation for the doors)

Proposed Timescale: 15/04/2016

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:
The timelines for completing investigations into allegations of abuse requires review.

15. 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:
• In order to improve timeliness of investigations we now have trained an additional 13 managers as investigators who will be available to conduct investigations under Trust in Care.

• In addition, an administrative support person is being recruited for Safeguarding and this will help with the workload of case management.

Proposed Timescale: 01/03/2016

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:
Aspects of the Statement of Purpose were not clear for example, the organisation structure and management details.

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

Please state the actions you have taken or are planning to take:
The statement of purpose will be revised to reflect:
• The organisational structure will be centre specific
• A lead will be identified and communicated in each house in the designated centre.
• The management structure will be clearly defined and communicated to all staff in this designated centre and will be reflected in the statement of purpose.
• The reviewed complaints procedures will reflect practice in the designated centre

Proposed Timescale: 30/03/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose was not available to residents in houses of the centre.

17. Action Required:
Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

Please state the actions you have taken or are planning to take:
• A current statement of purpose is in place in each house in this designated centre

Proposed Timescale: 01/01/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

18. 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:
• Unannounced provider visits reports will be submitted by the end of January 2016 to include an action plan with named actions and persons of responsibility.
• These action plans will be time framed and audits will be carried out by provider nominee or a representative to ensure improvements are carried out and overall learning has taken place.
• The Annual review of safety and Quality of care report will also reflect this learning.

Proposed Timescale: 30/01/2016
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

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

Please state the actions you have taken or are planning to take:
• A 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.
• A review has commenced (30/11/16) to map out a management model, staff rostering and role profile to be driven by assessed need. The line of accountability (including roles and responsibilities) from PIC down will be identified in each house in this designated centre.
• Two pilot sites have been identified to commence this.

• This will be reflected in the Standard Operating Procedure for Governance and Management and the Statement of Purpose.

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.

20. 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: 01/02/2016

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staff resources in one unit at night time required review

21. 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:
• A review of the duty on call nurse schedule of support for this house will be reviewed
• A risk assessment has been completed and support actions identified for the resident in this house. This remains a low risk as there have been no incidents in the last 12 months.
• The call system for this resident has been reviewed. Actions are being identified by the staff nurse for the clear rational for its use. The resident uses it to call staff when he feels unwell however he doesn't use it during the night when he needs the bottle (he feels he doesn't need help).
• The staff are also looking to see if a different type of call button is available as there is sound on the receiver and it could be seen as an infringement of privacy.
• There is sleepover staff in this house. The night manager presently has the float staff calling into the house once during the night. The plan from this month is to have the floating night staff based in this house as an additional support.

Proposed Timescale: 29/02/2016

Outcome 17: Workforce

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.

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

Proposed Timescale: 30/05/2016

Theme: Responsive Workforce

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

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

Please state the actions you have taken or are planning to take:
• The PIC will identify those staff who need to complete mandatory training in Fire Safety and Prevention of Abuse and schedule this training for the nearest available dates.

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 and prevention of abuse policies required review.

There was no infection control policy.

24. 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:
• Draft infection prevention & control policy is signed off and awaiting sign off by the Board in January.
• Once policy is approved an implementation plan will be designed which will include dissemination and communication of the policy and a schedule of refresher training for staff on infection prevention in conjunction with the training department. Dates for 2016 agreed with training department commencing 22nd Jan 2016.
• 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: 01/02/2016

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.

25. 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 are agency or relief staff.
• Who is in charge in the house
• A new template is being developed to capture this information
• The SIT (HSE service improvement team) continues to work in collaboration with Director of Services and Assistant Director of resources to modify rosters to ensure the supports are reflective of the needs in the house.

Proposed Timescale: 30/01/2016

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 four folders with large volumes of information.

26. 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.
• These Personal Plans have been piloted in this designated centre and are due for implementation in January 2016.
• Records management policy (Draft) which includes procedure for archiving will support the new personal file layout to ensure records required under Schedule 3 are easily located.
• The implementation of these personal plans will be coordinated by the quality department in collaboration with the PIC and key staff from each residential area.

Proposed Timescale: 01/04/2016