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:	Centre 2 - Cheeverstown House Residential Services (Active Age)
Centre ID:	OSV-0004925
Centre county:	Dublin 6w
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Cheeverstown House CLG
Lead inspector:	Maureen Burns Rees
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:
15 May 2018 09:30	15 May 2018 17:00
16 May 2018 08:30	16 May 2018 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This centre was placed on a six month regulatory plan by HIQA starting in February 2018. The regulatory plan was put in place as a result of significant non-compliances identified in a number of centres on the providers campus. The provider was required to submit an urgent action plan and assurance plan in respect of each of non compliances identified. This centre was one of three centres which had not had a registration decision made to date. It is proposed that a registration decision will be made at the end of the regulatory process for each of these centres. This centre was last inspected on the 12 and 13 of October 2017 and as part of this inspection the inspector followed up on actions from the last inspection.

How we gathered our evidence:
As part of the inspection, the inspector met with the person in charge, two clinical nurse managers, the head of care, the chief executive officer, five staff nurses, six care assistants, a house keeper and the house keeping supervisor. The centre comprised of four separate houses. Residents were met with, in each of the houses. The inspector met with 12 of the 15 residents living in the centre at the time of inspection. Residents spoken with outlined that they enjoyed living in the centre. All

of the residents were in good spirits and were observed to have warm interactions with the person in charge, clinical nurse managers and staff caring for them. The inspector reviewed care practices and documentation such as care plans, medical records, accident logs, staff files, policies and procedures and daily records.

Description of the service:
The designated centre consisted of four houses which were located on a campus containing a number of residential and day services operated by the provider. Each of the houses provided full-time residential care for adults over the age of 18 years. The service provided was described in the provider's statement of purpose, dated March 2018. Each of the residents had their own bedrooms which had been personalised to their own taste. There was adequate communal space within each of the houses. The houses had a number of communal garden areas within the campus with a number of the houses also having an allocated back garden area.

Overall judgment of our findings:
Overall, the inspector found that there had been significant improvements since the last inspection and that the provider had put in place a number of additional systems to ensure that the a good number of the regulations were being met or were in the process of being met. A governance plan and an urgent action plan had been put in place to address issues and non compliances identified. Senior management team walk arounds had been introduced to quality check those actions marked as complete on the urgent action plan.

The person in charge had been in the post for just over a year and demonstrated adequate knowledge and competence during the inspection. The inspector was satisfied that she was a fit person to participate in the management of the centre. There remained some areas for improvement as listed below and within the body of the report.

Good practice was identified in areas such as:
- Residents rights, dignity and privacy were found to be upheld. (Outcome 1)
- Arrangements were in place to support residents on an individual basis to achieve and enjoy the best possible health. (Outcome 11)
- There were systems in place to support staff in protecting residents in relation to medication management. (Outcome 12)

Areas for improvement were identified in areas such as:
- Improvements were required to ensure that progress in achieving goals set were effectively monitored, that the effectiveness of plans were reviewed, that residents family representatives and that members of the multidisciplinary team were involved in the reviews of personal plans put in place. (Outcome 5).
- Some improvements were required in relation to risk management and infection control arrangements. (Outcome 7)
- It was evident that the behaviours of a small number of residents in two of the houses were difficult for staff to manage in a group living environment and that this had the potential to have a negative impact for residents living in both of these houses. (Outcome 8)
- Some improvements were required so as to ensure that the person in charge

received appropriate supervision. (Outcome 14)
-There remained a small number of staff vacancies, mandatory training for a small number of staff was overdue and formal supervision arrangements for staff was not in place. (Outcome 17)

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

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

Theme:
Individualised Supports and Care

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

Findings:
Residents rights, dignity and privacy were found to be upheld.

Residents were consulted with and participated in decisions about their care and support and the organisation of each of the houses. Each of the residents had their own bedroom and their privacy and dignity was observed to be respected by staff. At the time of the last inspection, a process for night checks was in place without a rationale for individual residents. Since that inspection, a review had been completed and a rational for any night checks undertaken recorded based on individual residents needs.

There were appropriate arrangements in place for the management of complaints and complaints were found to have been responded to promptly.

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

Findings:
The centre had a policy on admissions which outlined the arrangements in place for admitting and transferring residents within the centre.

At the time of the last inspection it was identified that a number of residents did not have a written agreement in place and for those who did have one the services provided and fees payable were not correctly recorded. On this inspection, the inspector found that contracts had been revised to clearly list the services provided and fees payable. It was reported that all revised contracts had been sent out to residents family representatives for review and signing. However, at the time of inspection, a signed copy of the contract was not available on a number of the residents files.

Judgment:
Substantially Compliant

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:
Resident's individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified. However, improvements were required to ensure that progress in achieving goals set were effectively monitored, that the effectiveness of plans were reviewed, that residents family representatives and that members of the multidisciplinary team were involved in the reviews of personal plans put in place.

A full assessment of resident's needs was completed. A 'meaningfull activity' assessment

had also been completed for individual residents. These assessments informed personal plans and a newly introduced 'my life plans'. Plans in place detailed the individual needs and choices of residents but it was not always clear if the resident's family were involved in formulating the plans. Personal goals and actions required to achieve same were recorded for individual residents. A new template to evaluate goals set had recently been introduced.

There was evidence that personal plans had been reviewed within the last year. However, some reviews undertaken did not assess the overall effectiveness of the plans and did not involve the residents family or representative. Multi-disciplinary team meetings for individual residents had been undertaken in March 2018 and the minutes from these minutes stated that revisions had been agreed to individual personal plans. However, there was no record made of what the revisions were or if they had been made. Planning review meetings had been undertaken for a number of residents but the minutes of these meetings also included reference to notes from other health professional meetings held subsequently. Overall, the effectiveness of the plan in place did not appear to be reviewed as part of these meetings.

The inspector reviewed records of 'my weekly plans' for individual residents which showed that they were engaged in a fair range of activities in the local community and inside the centre. Visual timetables had been put in place for residents regarding their daily planners. However, in some cases, activities listed were not specific. For example, a number of timetables stated that resident would engage in an activity of interest. In other cases though, more specific activities had been identified. Residents and staff were observed to refer to their activity timetable and it was evident that it assisted them in organising their day. Good detail were recorded in 'my life plan' daily notes regarding activities residents had engaged in.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There were arrangements in place to promote and protect the health and safety of residents and staff. However, some improvements were required in relation to risk management and infection control arrangements.

Overall, suitable precautions were in place against the risk of fire. However, it was

identified that a number of staff had not been involved in a fire drill for an extended period and there were no formal oversight arrangements in place to ensure that all staff attended a fire drill at regular intervals. Training records showed that two staff were overdue to attend fire safety training but dates for same had been booked. At the time of the last inspection non compliances were identified in relation to the arrangements for evacuating residents and containing fires. These non compliances were found to have been suitably addressed on this inspection. A fire risk assessment had been undertaken. Records showed that fire fighting equipment, fire alarms and emergency lighting were appropriately installed and serviced by an external company. Formal safety checks of fire equipment and other safety precautions were undertaken at regular intervals. A procedure for the safe evacuation of residents and staff, in the event of fire, was prominently displayed in each of the houses. Each of the residents had a personal emergency evacuation plan in place which considered the mobility and cognitive understanding of the resident. Each of the houses had suitable night time staffing arrangements so as to ensure the safe evacuation of residents in the event of fire. The fire assembly point was identified with appropriate signage in an area to the front of each of the houses. Fire drills involving residents were undertaken at regular intervals with appropriate records maintained of those attending, time required for full evacuation and issues encountered.

There was a risk management policy in place, dated April 2015. However it did not meet all of the specific requirements of Regulation 26. At the time of the last inspection the system in place for the assessment, management and on-going review of risk, including the system for responding to emergencies required review to ensure that it reflected actual practice. On this inspection the inspector found that individual risk assessments for residents had been undertaken with plans put in place to address risks identified. Site-specific risk assessments had been undertaken and appropriately recorded. A risk register was maintained as a 'living' document in each of the houses. There was a health and safety policy and procedure, which was specific to the centre. Health and safety checks were completed at regular intervals. There was an emergency plan in place to guide staff in responding to an emergency. The provider had a risk management department which was accessible as a resource for the centre.

There were arrangements for investigating and learning from serious incidents and adverse events involving residents. From a review of a sample of case notes, the inspector found that incidents had been appropriately reported with a record maintained of actions taken and further actions required. There was evidence that individual incidents were reviewed and discussed at staff team meetings. The providers risk management department had completed an analysis and trending report of the number and type of incidents across the centre and compared to centres across the service. This provided opportunities for shared learning across the service.

There were procedures in place for the prevention and control of infection. However, on the day of inspection a poignant smell was identified in one of the residents bedrooms which persisted even after cleaning. On the second day of inspection, the smell in this room had improved but a review of the cleaning schedules for the room was required. It was also observed that a toilet area had been left for an extended period, in an unhygienic state. There was an infection control policy and procedure. There were cleaning schedules in place and sign off sheets. Colour coded cleaning equipment was in

place and appropriately stored. The inspector observed that there were facilities for hand hygiene available. Overall areas were observed to be clean and tidy.

Judgment:
Substantially Compliant

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

Findings:
There were measures in place to safeguard residents. However, compatibility issues in two of the houses were impacting upon the quality of life of residents.

There was a policy and procedure on protection of vulnerable persons, dated March 2015, which was in line with the national guidance. The person in charge and staff interviewed were knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. There had been a small number of suspicions of abuse in the previous 12 month period and these were found to have been appropriately responded to. Risk assessments and safeguarding plans had been put in place where required. There was evidence that safeguarding arrangements were regularly discussed at staff handover with a 'safety pause' and at team meetings, The providers safeguarding officer had visited individual houses to brief staff.

Arrangements were in place to provide residents with emotional and behavioural support that promoted a positive approach to the management of behaviour that challenges. The centre had a policy on promoting positive approaches, dated March 2017. At the time of the last inspection, it was identified that some behavioural support plans did not provide sufficient detail to guide staff. Since that inspection, all behaviour support plans had been reviewed and revised with input from psychology, clinical nurse specialist and the staff team. A sample of behaviour support plans reviewed were found to provide sufficient detail to guide staff in meeting the needs of residents identified to require such support. Training records showed that staff had received appropriate training in a recognised behaviour management approach. Staff interviewed were familiar with the management of challenging behaviour and de-escalation techniques.

There was evidence that efforts were made to identify and alleviate the causes of residents' specific behaviours. However, compatibility issues in two of the houses were impacting upon the quality of life of residents. There was evidence that the provider had put some measures in place to support each of the residents. These included the introduction of a bleep alert system to call additional staff to the area where required to support other residents. A summary information sheet for individual residents had been placed at a convenient location providing guidance for any staff arriving at short notice to the area on how best to support individual residents.

There was a policy and procedure on restrictive practices, dated October 2016. At the time of the last inspection, it was identified that some restrictive practices were not applied in accordance with evidence based best practice. On this inspection the inspector found that restrictive practices in place were approved and reviewed by the provider's behaviour support team and the rights review committee. There was evidence that all alternatives were used before a restrictive practice would be used and that the least restrictive procedure for the shortest duration necessary was used. A safety and well being observation form was completed whilst individual residents were using specific restraints and recorded in a critical incident form. There was a restrictive practice log maintained. Risk assessments had been completed for restrictive practices in place.

The centre had an intimate care policy, dated October 2014. Intimate care assessments and plans were in place for residents who required same. These were found to provide a good level of detail to guide staff in meeting the intimate care needs of these residents.

Judgment:
Non Compliant - Moderate

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:
Arrangements were in place to support residents on an individual basis to achieve and enjoy the best possible health.

Residents' healthcare needs were met by the care provided. A number of the houses had a registered staff nurse on duty at all times whilst other houses had access to a staff nurse 24/7 within the campus. A general practitioner (GP) was based on the

campus two days per week. Each of the residents had their own GP and access to an out-of-hours doctors service. Residents had access to a number of other therapeutic supports. These included: speech and language therapy, dietician, physiotherapy and clinical nurse specialists. Records were maintained of all contact with GPs and other health professionals. A register of serious health issues in each housed was recorded.

At the time of the last inspection, the inspector had found that the details contained within some plans did not guide staff effectively to ensure that the residents received the required healthcare provision and that some medical treatments recommended for individual residents was outstanding for an extended period. On this inspection,and of the sample of files reviewed, it was found that a comprehensive health assessment and plans had been completed for residents. All recommended treatments had been provided. A log was maintained of health screening and checks required for individual residents with dates next due where applicable.

Residents dietary needs were being met. There was a food, nutrition and hydration policy, dated October 2016. The inspector observed that a healthy diet and lifestyle was promoted in the centre. There were arrangements in place for residents to be involved in choosing and assisting to prepare meals in individual houses. A weekly menu planner was agreed with residents and this showed that a varied and nutritious diet was provided for residents. Information regarding healthy meal planning was available in each of the houses for staff and residents. Feeding, eating, drinking and swallowing (FEDS) assessments had been completed for residents identified to require same. Specific plans put in place and recommendations from dieticians were found to be implemented. Each of the houses had a fully equipped kitchen and a dining area, with adequate seating to allow meal times to be a social occasion.

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:
The systems in place to support staff in protecting residents in relation to medication management were found to be satisfactory on this inspection.

There was a policy and procedure on medication administration and administration, dated April 2015. A secure storage press was in place in each of the houses. Registered

staff nurses were responsible for the administration of medications across the centre. Staff spoken with had a good knowledge of the requirements for the safe administration and management of medications. The inspector reviewed a sample of medication prescription and administration records and found that they had been appropriately completed and were regularly reviewed by the residents general practitioner (GP). Individual medication management plans were in place. Procedures were in place to check all medications ordered and delivered by pharmacy with medication stock control logs maintained. A pharmacist was available on the campus three days per week.

At the time of the last inspection it was identified that a maximum dosage for PRN or as required medications was not always stated, a PRN medication had not been appropriately labelled with the residents name, a PRN medication was not available for a resident in the centre and inaccuracies were identified in relation to the stock balances recorded. On this inspection the inspector found that an adequate supply of all medications was available in the centre and that PRN medications had been appropriately prescribed and that protocols were in place for residents who were identified as requiring these. A PRN administration record was maintained of all administrations.

There were arrangements in place to review and monitor safe medication management practices in the centre. Medication audits were undertaken on a three monthly basis. There was evidence that the output from these audits, with any learning identified was discussed at staff team meetings.

Judgment:
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:
Arrangements in place to monitor the quality and safety of care and support in the centre had improved since the last inspection. However, some improvements were required so as to ensure that the person in charge received appropriate supervision.

There was a management structure in place. The person in charge reported to the head of care who in turn reported to the chief executive officer. Staff interviewed had a clear understanding of their role and responsibility, and of the reporting structure. There was a manager available 24/7 on the campus for support. Since the last inspection, changes had been made to the roster system with the introduction of an electronic roster to replace the printed rosters in each house, so that any changes made to the roster by a manager or the rostering team were immediately available within each house. Lead staff member on each shift were clearly indicated on the rosters reviewed on this inspection. There were weekly staff meetings held in each of the individual houses which were attended by staff from the specific house and the clinical nurse manager who oversaw the house. These informed centre meetings were held on a monthly basis and attended by the person in charge, clinical nurse managers and staff from each of the four houses.

The person in charge held a full-time position and was not responsible for any other centre. She was supported by two clinical nurse managers. The person in charge had been manager in the centre for the past year but had been a clinical nurse manager in the centre for 2 years before that. She had been working within the service for more than 14 years. She was a registered nurse in intellectual disabilities and held a degree in nursing. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards and had a good understanding of the individual care needs of each of the residents. However, the person in charge had not had formal supervision or performance review with her line manager for an extended period. It was noted that she had regular informal contact with her line manager but formal arrangements to ensure that she performed her duties to the best of her ability were not in place.

This centre is one of four centres operated by the provider which was placed on a six month regulatory plan by HIQA starting in February 2018. As a consequence the provider had put in place a governance plan and an urgent action plan to address non compliances identified in previous inspections. At the time of the last inspection, the management systems in place did not ensure that the service provided was safe, consistent and effectively monitored. Since that inspection, a range of audits had been undertaken in the centre as part of an audit cycle. These included audits of personal plans, medication management and residents finances. There was evidence that issues identified were reported to the senior management team with an action plan and timelines to address issues identified. A schedule of walk-rounds by members of the senior management team had been undertaken to quality check against those actions marked as complete on the urgent action plan and assurance statement to HIQA. An annual review of the quality and safety of care as required by the regulations had also been completed. Unannounced visits to the centre on a six monthly basis, as per the requirements of the regulations had been fully undertaken.

Judgment:
Substantially Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
There had been recent staff recruitment and overall the staff numbers and skill-mix were appropriate to meet the assessed needs of residents in the centre. However, there remained a small number of staff vacancies, mandatory training for a small number of staff was overdue and formal supervision arrangements for staff was not in place.

There was a staff roster in place which showed that there were adequate numbers and skill-mix of staff on each shift to meet the needs of the residents. Since the last inspection, an assessment of need had been completed for individual residents and the staff rosters had been changed to ensure more appropriate staffing in some areas. The roster had also been computerised which facilitated it being a 'living' document which was coordinated and maintained centrally. Five new staff members had recently been recruited to work in the centre. The person in charge reported that the whole time equivalent staff complement for the centre remained short by two staff members. There was evidence that recruitment was underway for these positions. It was noted that a regular panel of relief staff were used to cover staff vacancies which provided some consistency of care for the residents.

The inspector noted that copies of the standards and regulations were available in the centre. Staff interviewed were knowledgeable about their role and of the regulatory requirements.

There was a training and development policy in place, dated July 2017. There was a training programme in place which was coordinated centrally by the provider. Staff training records reviewed by the inspector showed that a small number of staff were overdue to attend mandatory training. It was noted that dates for these had been identified and booked. Other training to meet specific needs of residents had been identified and sourced.

Overall effective recruitment and selection arrangements were in place. There was a recruitment and selection policy in place, dated January 2017. At the time of the last inspection, it was identified that some of the information as required by schedule 2 of the regulations were not in place. The provider reported that an audit of files was subsequently completed with deficits addressed. On this inspection the inspector reviewed a sample of eight staff files and found that the information as required by

schedule 2 of the regulations was in place with the exception of one staff file whereby evidence of the persons identity, including a recent photograph were not on file. This was rectified on the day of inspection.

There were limited formal supervision arrangements in place for staff. This had been highlighted on previous inspections and meant that staff might not be appropriately supported or have appropriate oversight so as to ensure that they are performing their duties to the best of their abilities. It was reported that a supervision policy was being developed. It was noted that an annual performance review was completed.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Maureen Burns Rees
Inspector of Social Services
Regulation Directorate
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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Cheeverstown House CLG
Centre ID:	OSV-0004925
Date of Inspection:	15 and 16 May 2018
Date of response:	26 June 2018

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 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A signed copy of the contract was not available on a number of the residents files.

1. 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

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

terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
Long stay charge reassessments have been completed 21/06/2018, New contracts with the revised LSC will be sent to residents and next of kin.
For one resident, an independent advocate will be involved as she has no living family.
For another resident, if he chooses not to have family involved, we will contact the independent advocacy services (if he agrees to engage).

Proposed Timescale: 31/08/2018

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:
Multi-disciplinary team meetings for individual residents had been undertaken in March 2018 and the minutes from these minutes stated that revisions had been agreed to individual personal plans. However, there was no record made of what the revisions were or if they had been made. .

2. 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:
A review of the form utilised to capture recommendations and minutes at multidisciplinary reviews is currently being undertaken. This will be used at the DC2 schedule of team reviews in October.

Proposed Timescale: 31/10/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence that personal plans had been reviewed within the last year. However, some reviews did not involve the residents family or representative.

3. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Families will be invited to participate in the review of the resident's personal plan annually in accordance with resident's wishes. This annual review will be carried out in conjunction with the MDT. Residents, families (where appropriate) are invited to attend and fully participate in case conferences.
For the one resident, we will invite her independent advocate as she has no living family.

Proposed Timescale: 31/10/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence that personal plans had been reviewed within the last year. However, some reviews undertaken did not assess the overall effectiveness of the plans.

4. 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:
There are 17 residents in DC2. The PIC has commenced the review of the personal plans with the DC management team.
My Life Plan training includes giving staff guidance on how to review the effectiveness of a plan and all staff currently employed in DC2 has received this training.
The evaluation form has been revised by the quality department to give clearer guidance to staff which will ensure that all relevant information and topics are covered within the review to measure the effectiveness of the plan.
Families will be invited to participate in the review of the resident's overall personal plan annually

Proposed Timescale: 31/10/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Multi-disciplinary team meetings for individual residents had been undertaken in March 2018 and the minutes from these minutes stated that revisions had been agreed to individual personal plans. However, there was no record made of what the revisions were or if they had been made.

5. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the

personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
A review of the form utilised to capture recommendations and minutes is currently being undertaken and this will allow for greater clarity going forward.

Proposed Timescale: 31/10/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was a risk management policy in place, dated April 2015. However, it did not meet all of the specific requirements of Regulation 26

6. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
The risk management policy is currently under review and on completion will contain all requirements set out under Regulation 26.

Proposed Timescale: 30/07/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A poignant smell was identified in one of the residents bedrooms which persisted even after cleaning.

It was observed that a toilet area had been left for an extended period, in an unhygienic state and that this had not been identified by the staff member who had been providing intimate care support for the identified resident.

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

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

This issue was discussed with staff and the external cleaning company staff and a deep clean of the bedroom was completed. A schedule of works has been agreed with the housekeeping staff including daily washing of mattress and washing of bedclothes.

Toilet -
When a staff member observes that the toilet requires cleaning, it is the responsibility of that staff member to attend to the cleaning task. This has been re-iterated at the house meeting.
A resident uses this toilet independently and at times the toilet requires to be cleaned after she uses it. Staff in the house will check the toilet on a more regular basis (and record this check on the current recording sheet).

Proposed Timescale: 17/05/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was identified that a number of staff had not been involved in a fire drill for an extended period and there were no formal oversight arrangements in place to ensure that all staff attended a fire drill at regular intervals.

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

Please state the actions you have taken or are planning to take:
Those staffs have been identified and the PIC has a schedule of fire drills arranged and planned to ensure involvement of all staff and residents.

Proposed Timescale: 30/09/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The compatibility of residents in two of the houses were difficult for staff to manage in a group living environment. Ultimately, the behaviours had the potential to have a negative impact on other residents living in the centre.

9. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
A resident from each of the houses referred to have been identified to transition to a

community house. The availability of the house is confirmed and the transition plan for each resident has commenced.

Proposed Timescale: 31/12/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not had formal supervision or performance review with her line manager for an extended period. It was noted that she had regular informal contact with her line manager but formal arrangements to ensure that she performed her duties to the best of her ability were not in place.

10. 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:
Formal supervision was carried out between the PIC and Head of Campus and Transition on 17/06/18

Supervision from the Head of Campus and PIC will take place quarterly, with a focus on support of the PIC in carrying out her regulatory function and Cheeverstown policy and practice.

Proposed Timescale: 31/08/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The whole time equivalent staff complement for the centre was short by two staff members.

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

Please state the actions you have taken or are planning to take:
The 2 vacant positons are maternity leave short term vacancies. Recruitment efforts to

fill these vacancies on a specified purpose contract have been unsuccessful to date, but efforts are ongoing.
Vacant shifts are therefore filled by Support Team members familiar with the support needs of the residents in DC2. The use of unfamiliar agency staff is a last resource.

Proposed Timescale: 30/09/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff training records reviewed by the inspector showed that a small number of staff were overdue to attend mandatory training.

12. 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:
All staff are scheduled to attend planned training sessions on mandatory training.

Proposed Timescale: 31/10/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were limited formal supervision arrangements in place for staff. This had been highlighted on previous inspections and meant that staff might not be appropriately supported or have appropriate oversight so as to ensure that they are performing their duties to the best of their abilities.

13. 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:
Staff will receive formal supervision by a DC manager quarterly. This meeting will compose of one Performance Development Planning meeting and 3 formal supervision meetings. The PIC will schedule staff a date for this supervision. Staff will receive one to one management supervision within the next 3 months

Proposed Timescale: 31/08/2018