Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Centre 2 - Cheeverstown House Residential Services
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Announced
Date of inspection:	29 November 2022
Centre ID:	OSV-0004925
Fieldwork ID:	MON-0029108

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This designated centre comprises of 4 houses located on the residential campus in South Dublin. The centre provides 24 hour residential care and support for adults both male and female. The capacity of the service is for up to 16 adults with intellectual disabilities including some adults with physical and sensory disabilities. Residents all have their own bedrooms and each house while configured differently, contains a kitchen, laundry room, two sitting rooms and adequate numbers of bathrooms. Each house had a garden area to the rear of the house and residents had access to a number of communal garden areas. The centre's staff team consisted of a person in charge, clinical nurse managers, staff nurses, care assistants and housekeeping staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 29 November 2022	10:30hrs to 17:30hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

From what the inspector observed, there was evidence that the residents living in the centre received good quality care and support.

The centre comprises of four separate units which were located adjacent to each other within a campus based setting operated by the provider. The layout of three of the units was similar and each contained, three accessible bathrooms, a large kitchen come dining area, utility and laundry room, an open plan day room area and a separate sitting room and medication room. Each house had a small back garden but access to a central communal garden and other shared gardens within the campus. The centre was located in close proximity to local amenities, including, shops restaurants, cinema, swimming pool, public parks and public transport links.

There were long-term plans to de-congregate the centre in line with the HSE's "Time to Move On from Congregated Settings : A Strategy for Community Inclusion, (2011)". A defined time frame for the de-congregation of the centre had not yet been determined. There was some but limited evidence of consultation with families with the residents and their families to determine their needs, will and preferences in relation to their future life plans as they transition to live in their own home within the community. The person in charge reported that further consultation and a discovery process was planned once a de-congregation time-line had been determined. There was a policy stating that there would be no new admissions into the centre but there was an allowance made to facilitate residents to transfer based on need to and from other designated centres based on the same campus.

Each of the 12 residents had been living together for an extended period and were reported to get along well together. Over the course of the inspection, the inspector met briefly with 10 of the residents. Although the majority of the residents met with were unable to tell the inspector their views on the quality of the service, they appeared in good spirits. Two of the residents spoke with the inspector and told her that they were happy living in the centre. A number of residents were observed to go out for walks on campus with staff and for lunch in a restaurant based on the campus. Two of the residents were supported to attend their weekly massage appointment within the community and one resident went to the cinema. One of the residents attended swimming in the providers swimming pool located on campus. Staff were observed to interact with the residents in a caring and respectful manner. A number of the residents had limited speech but were observed to be supported by staff to communicate their feelings and wishes.

There was some evidence that residents and their representatives were consulted and communicated with about decisions regarding their care and the running of the centre. Each of the residents had regular one-to-one meetings with their assigned key workers and there were regular residents meetings in each of the houses. Residents were supported to communicate their needs, preferences and choices at these meeting in relation to activities and meal choices. The inspector met with the

relatives of two of the residents. One of these relative reported that they were happy with the care and support that the residents were receiving. However, the relative of the second resident had some concerns which were being dealt with through the provider's complaint management process. The provider had consulted with residents' families as part of its annual review of the quality and safety of the service and the feedback from families was overall positive. A number of residents families completed an office of the chief inspector questionnaire in preparation for this inspection and overall this indicated that these families were happy with the care and support that their loved ones were receiving.

Residents were supported and encouraged to maintain connections with their friends and families. A number of the residents were supported to visit their family home on a regular basis and visits by friends and family to the centre were facilitated.

Overall, residents were supported to engage in meaningful activities in the centre. However, it was noted that some of the residents had minimal opportunities for community integration and were not being adequately supported to engage in meaningful activities within the local community. This meant that these residents were not being supported to develop a valued social role within the community. The evidence to support this position was not clear, although it was recognised that a number of the residents had complex physical and medical needs. One of the 12 residents was engaged in a formal day service programme located on the campus. It had been assessed that an individualised service, by staff in the centre, better met the other residents needs. Examples of activities that residents engaged in within the centre and in the community included, walks within the campus and to local scenic areas, church visits, beauty treatments, arts and crafts, dining out, cinema trips and shopping. A record was maintained of activities which the residents participated in. The centre had access to two vehicle between the three houses but could also access additional vehicles and transport through the transport manager who was located on campus. This facilitated residents to access community activities and visits to families. Residents had access to a small garden to the rear of each house but also a communal garden area with raised flower beds and seating areas. There was also a swimming pool, gym and sensory room, 'the Zen Den' which residents across the campus could access.

The full competency of staff was in place at the time of inspection. This provided consistency of care for the residents. Staff were observed to be respectful, kind and caring. Each of the residents had assigned key workers. The inspector noted that residents' needs and preferences were well known to staff met with and the person in charge.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

There were suitable governance and management arrangements in place to promote the service provided to be safe, consistent and appropriate to residents' needs.

The person in charge was suitably qualified and experienced. She had a good knowledge of the assessed needs and support requirements for each of the residents and of the requirements of the regulations. The person in charge had a background as a registered staff nurse in intellectual disabilities and held a diploma in leadership and healthcare. She had been working within the service for an extended period and had more than six years of management experience. She was in a full-time position and was not responsible for any other service. The person in charge reported that she felt supported in her role and had regular formal and informal contact with her manager.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge was supported by two clinical nurse managers (CNM1). She reported to the head of support and living services who in turn reported to the director of operations. The person in charge and head of support of living services held formal meetings on a regular basis. There was a governance contingency plan in place for any absences.

The provider had completed an annual review of the quality and safety of the service and unannounced visits, to review the safety of care, as required by the regulations. A number of other audits and checks had been completed. Examples of these included, infection prevention and control, finance, incident reports and medication. There was evidence that actions were taken to address issues identified in these audits and checks. There were regular staff meetings and separately management meetings with evidence of communication of shared learning at these meetings.

The staff team were found to be appropriately qualified and experienced to meet the residents needs. There was a registered staff nurse rostered on each shift in two of the three occupied houses. This supported the medical needs of residents in these houses. The full complement of staff were in place at the time of inspection. This provided consistency of care for the residents. The actual and planned duty rosters were found to be maintained to a satisfactory level. There were staff allocation task sheets maintained for each shift.

A record of all incidents occurring in the centre was maintained and overall where required, these were notified to the Chief Inspector of Social Service, and overall within the time frames required in the regulations.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff members employed in the centre to meet the assessed needs of the residents. The full complement of staff were in place. There was a consistent team of staff working with the residents. The actual and planned duty rosters were found to be maintained to a satisfactory level.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with appropriate training to support them in their role. All training was coordinated centrally and records were maintained. There were a small number of staff overdue to attend behaviour support and manual handling training. However, this was scheduled for the week following this inspection. Suitable staff supervision arrangements were in place.

Judgment: Compliant

Regulation 23: Governance and management

Suitable governance and management arrangements were in place. The provider had completed an annual review of the quality and safety and unannounced visits, to review the safety of care, as required by the regulations. There were clear lines of accountability and responsibility.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place, which included all of the information

required by the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications of incidents were reported to the Chief Inspector in line with the requirements of the regulations. There were arrangements in place to review trends of incidents on a quarterly basis or more frequently where required.

Judgment: Compliant

Quality and safety

Overall, the residents living in the centre appeared to receive person-centred care and support which was of a good quality. However, some improvements were required regarding: the maintenance of the premises, the arrangements for review of residents' personal plans and to identify meaningful goals and social care activities for some of the residents.

The majority of residents living in the centre had complex needs. Overall, residents' medical needs and welfare was maintained by a good standard of evidence-based care and support. A staff nurse was rostered on each shift in two of the three occupied houses to ensure that residents' medical needs were being met. Personal care and support plans were in place for each of the residents which reflected the assessed needs of individual residents and outlined the support required in accordance with their individual health, communication and personal care needs and choices. Detailed communication passports were in place to guide staff in supporting the resident to effectively communicate. There were specific health assessments and plans in place for residents identified to require same. There were some but limited goals and activities identified for some residents in areas such as community integration and activities. Monitoring of progress in achieving identified goals was not clearly documented in some cases. In other cases, goals identified had not been progressed and or goals set were not specific or measurable. The inspector reviewed a sample of personal plans and found that the majority of the sample had been reviewed on an annual basis. However, in one of the annual reviews, there was no evidence that family members had been consulted as required by the regulations. This resident's family when spoken to advised that they had not been consulted with, regarding the resident's personal plan.

The health and safety of the residents, visitors and staff were promoted and protected. Individual and environmental risk assessments had been completed and

were subject to review. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents. This promoted opportunities for learning to improve services and prevent incidents. Suitable arrangements were in place for the management of fire.

There were suitable infection control procedures in place. However, it was noted that there was worn and chipped paint on some walls and woodwork, the surface on some wardrobes and sink surrounds were broken, some tile grouting was worn stained or missing in a number of bathrooms. This meant that these areas were more difficult to effectively clean from an infection control perspective. The provider had a contingency and cohorting plan for COVID-19 and a range of standard operating procedures which were in line with national guidance. A risk assessment for COVID-19 had been completed. A cleaning schedule was in place which was overseen by the person in charge. All areas appeared clean. Cleaning was completed by household staff from an external company. Colour coded cleaning equipment was available. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. Specific training in relation to COVID-19, proper use of personal protective equipment (PPE) and effective hand hygiene had been provided for staff.

There were measures in place to protect residents from being harmed or suffering from abuse. However, a number of residents presented with behaviours which could be difficult on occasions to manage in a group living environment. This had the potential to negatively impact upon some of the other residents. Staff spoken with were knowledgeable about safeguarding procedures and of their role and responsibility. Appropriate arrangements were in place to report and respond to any safeguarding concerns. The provider had a safeguarding policy and safeguarding plans were needed.

Residents appeared to be provided with appropriate emotional and behavioural support. It was noted that a number of residents presented with behaviours which could be difficult for staff to manage in a group living environment. However, it was considered that there were appropriate guidance in place for staff to support residents and that generally incidents were well managed and residents were suitably supported.

Regulation 17: Premises

The centre was comfortable and homely. As identified under regulation 27, maintenance was required in some areas but overall the centre was in a reasonable state of repair. It was noted that a significant amount of equipment was required for use by the residents and arrangements for the storage of same was limited in some areas.

Judgment: Compliant

Regulation 26: Risk management procedures

There were suitable risk management arrangements in place. Individual and environmental risk assessments had been completed and were subject to review. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified.

Judgment: Compliant

Regulation 27: Protection against infection

There were arrangements in place for prevention and control of infection. However, it was noted that there was worn and chipped paint on some walls and woodwork, the surface on some wardrobes and sink surrounds were broken, some tile grouting was worn stained or missing in a number of bathrooms and some wall tiles were broken. This meant that these areas were more difficult to effectively clean from an infection control perspective.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable precautions had been put in place against the risk of fire in each of the houses. Fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company. There were adequate means of escape and a procedure for the safe evacuation of residents was prominently displayed in each house. Fire drills involving residents had been completed at regular intervals and each of the houses was evacuated in a timely manner.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Overall, residents' medical needs and welfare was maintained by a good standard of evidence-based care and support. However, there were some but limited goals and activities identified for some residents in areas such as community integration and

activities. Monitoring of progress in achieving identified goals was not clearly documented in some cases. In other cases, goals identified had not been progressed and or were not specific or measurable. In a sample of files reviewed. There was no evidence that the annual review for one of the residents had involved consultation with the residents and their representatives as required by the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

The residents' health needs were being met by the care and support provided in the centre. There was a registered staff nurse rostored on duty in two of the three occupied houses. Detailed health action plans were in place. Records were maintained of all contacts with health and social care professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents appeared to be provided with appropriate emotional support. Support plans were in place for residents who were identified as needing that support. As referred to under regulation 8, a number of the residents presented with behaviour which could be difficult to manage in a group living environment. However, incidents appeared to be well managed with residents supported.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. However, a number of residents presented with behaviours which could be difficult on occasions to manage in a group living environment. This had the potential to negatively impact upon some of the other residents. Safeguarding information was on display and included information on the nominated safeguarding officer.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The residents' rights were supported by the care and support provided in the centre. There was a user friendly version of a charter of rights in each of the houses. Residents were observed to be treated with dignity and respect. Residents had access to advocacy services if so required. A picture and the contact details of an independent advocate were on display in each of the houses.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Centre 2 - Cheeverstown House Residential Services OSV-0004925

Inspection ID: MON-0029108

Date of inspection: 29/11/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: Works will be completed on areas idenitified on Inspection to ensure effective cleaning from an infection control perspective. These included Worn and chipped paint on walls and woodwork Surface on wardrobes and sink surrounds that were broken Tile grouting and replacement of tiles in bathrooms	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: A review and evaluation of each residents My Life Plan will be completed with the focus on community integration. This review will be completed in consultation with the resident, families and MDT.	
Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All residents have personal plans which assess the person's needs and wishes in relation to positive care supports in a manner that respects the resident's dignity. These Positive care support plans are reviewed regularly and updated.
• Residents are educated on skills of self-care and are supported to understand what to do to protect themselves.
• Staff are trained to recognise, respond and support residents during periods of distress, whilst ensuring the safeguarding of others.

It is planned that all residents will be transitioned from Cheeverstown centre in line with our Strategic Priorities 2021-2026. The resident will be kept at the centre of their transition plan which will identify compatibility for further living options.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 27	The registered provider shall 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.	Not Compliant	Orange	31/03/2023
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall	Substantially Compliant	Yellow	28/02/2023

	be 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.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	28/02/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/01/2023