

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003441
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Leone Ewings
Support inspector(s):	Sheila McKeivitt
Type of inspection	Announced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
07 April 2015 10:00	07 April 2015 17:30
08 April 2015 10:00	08 April 2015 17:00

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

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for registration by the provider. This was the second inspection of the centre, this inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The centre consists of one purpose built two storey building originally constructed in 1974, and located in the Phoenix Park close to the city centre and its' amenities.

The views of residents and staff of the centre were also sought on inspection. Overall during the inspection the residents confirmed satisfaction to inspectors with service

provision and that they enjoyed a good quality of life. Questionnaires completed by residents and relatives' were received by the Authority during and following the inspection. The opinions expressed through the questionnaires were broadly satisfactory with all aspects of services and facilities provided. In particular, relatives were satisfied with the manner in which staff supported each resident to make choices and decisions about their day to day lifestyle.

As part of the application for registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider for the purposes of application to register were found to be satisfactory. However, evidence of planning compliance for the premises has not been received as part of the application to register.

The main aim of this residential service is to provide long term residential care to male and female people living with disabilities. Residents with physical, intellectual sensory and neuro-disability are accommodated and live at the centre together. A large number of residents have lived at the centre for an extended number of years and are very settled in their environment.

The management team at the centre had changed since the time of the last inspection, and a service co-ordinator was now part of the management team and acts as deputy to the person in charge. All documentation submitted relating to the person in charge and deputy manager was complete and satisfactory. The fitness of the person in charge and service co-ordinator was assessed throughout the inspection process to determine fitness for registration purposes. Both completed interviews and were found to have satisfactory knowledge of their roles and responsibilities, under the legislation and sufficient experience and knowledge to provide safe and appropriate care and supports to all residents. The provider nominee will be interviewed at a later date as part of the registration process.

Evidence of good practice was found across all 18 outcomes, the provider and person in charge had partially or fully addressed the six outcomes where non-compliances from the last inspection on 26 and 27 August 2014. The inspector was satisfied that improvements relating to fire safety, medication management, personal plans and had been addressed by the provider and person in charge. However, further improvements were required particularly relating to the provision of adequate healthcare and recruitment of a clinical nurse manager to supervise and monitor residents with assessed healthcare needs, which had not been fully addressed by the provider further to the last inspection.

6 out of 18 Outcomes inspected against were deemed to be in compliance with the Regulations. However, improvements were required relating to 12 of the Outcomes:

- complaints outcomes and records
- contracts of care
- personal planning
- premises
- risk management
- adult safeguarding
- notification of incidents

- healthcare
- statement of purpose
- governance and provision of an annual quality and safety review
- staffing and skill mix
- provision of final admissions transfer and discharge policy
- directory of residents

The action plans at the end of this report identifies the 12 outcomes under which these improvements are required.

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):

No actions were required from the previous inspection.

Findings:

Residents confirmed they were consulted with, and participated in decisions about care supports and about the organisation. All residents who spoke with the inspectors confirmed they were comfortable about voicing their opinions and thoughts freely in their own home. Residents were clear about their rights and confirmed that they were fully respected by others who lived at the centre and staff supporting their lifestyle. Advocacy was discussed with the person in charge and the inspector was informed that this was an area where access to advocacy services and clear information about their rights was required. Improvements were required relating to documenting complaints management, and information about the proposed de-congregation process for residents. Respondents to the pre-inspection questionnaires were concerned about the arrangements to de-congregate the service and required further reassurances from the provider.

Each resident's privacy and dignity was respected, all bedrooms were private, and residents could also receive visitors in private. However, there was communal access to assisted shower, toilet and bathing facilities. Each resident was enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise independence and choice.

The inspector was satisfied that the complaints of each resident, his/her family, or representative were listened to and acted upon and there was an appeals mechanism to the provider in place. Residents and relatives confirmed that they knew who to discuss any issues or complaints should they arise in the future.

The complaints records were reviewed and discussed with the person in charge and

required some improvement. The service quality officer confirmed that reports and any feedback received from service users was maintained on a database with a view to service improvement. A report for 2014 and 2015 was requested and given to the inspectors. There had been 19 complaints during 2014, most had been resolved at local level and two remained unresolved. A request was made to submit the outcome of the two unresolved complaints one of which had been further escalated within the terms of the current complaints standard procedure. Evidence of satisfaction of the complainant with the outcome of the complaints was not fully documented in all cases. The current report for 2015 showed no complaints on file. The person in charge confirmed that there had been improvements mainly relating to accommodation, food, and hygiene matters, and she would ensure that the remaining unresolved complaint would be addressed with the provider at the earliest opportunity.

The inspectors reviewed the systems in place to support residents with management of finances and found that they were clear and transparent, with receipts and the resident retained control over their own monies which were available to facilitate social activities, outings and holidays. The inspector discussed the systems in place with a number of residents and staff which involved collecting pensions and management of their own funds. The current system was fully documented and found to be in line with best practice, and in line with the written policy.

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):

No actions were required from the previous inspection.

Findings:

Residents were able to clearly communicate their needs at all times, and good practice was observed. Individual communication assessments were in place for all residents, which identified verbal and non-verbal communication methods in use. The inspector saw that all staff spoke with and listened attentively to each resident in a patient and respectful manner. Specialist and individual communication techniques were employed and shown to the inspector. For example, one resident used a hand held electronic device to communicate and an app. Another resident used an eye based technique which he had taught to staff at the service. The staff had included detailed communication plans relating to appropriate responses when a resident may express a worry or concern which allowed for consistency and reassurance to be offered at this time. Staff were easy to find and volunteers were seen to interact well with residents and visitors during the day, as well as accompanying residents to their external

activities.

The inspector saw both residents had access to music and DVD systems and televisions in their bedrooms and in the activities and living room. There were portable telephones accessible in the house. The use of a broadband communication system was facilitated with computer available to those who wished to access them. Some residents had additional television channels from an external provider which they paid for this service on an individual basis. However, some of the residents informed inspectors that the broadband was of variable strength in different parts of the building. One resident had moved room to facilitate better access to broadband.

Judgment:

Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were supported to develop and maintain personal relationships and links with the wider community. Families were well informed relating to residents their wellbeing and informed of any significant events, in accordance with the wishes of the residents.

There were no restrictions on visitors. Residents told the inspector that they had visitors of their choice visit them in their home. Most residents' had chosen for their families to be involved in their care and the person in charge discussed that family members will be invited to attend a meeting to discuss the resident's personal plan for 2015. Family contacts and any communication was recorded on the daily report sheets. The inspectors met with relatives who confirmed they had contact numbers for staff and could speak to a staff member at any time to get an update or make arrangements to go home at weekends or holidays. Each resident had personal family photographs and mementoes in their own rooms, and personalised their space to their liking.

Residents used facilities in their local community and had links to nearby facilities and amenities in the locality. They told the inspector they regularly visited the barber, hairdresser or nearby restaurants for lunch. They mainly used the transport bus or car to access shops to purchase clothing and items of their choosing.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The contracts of care were fully reviewed and found to be available for all residents, and this had been put in place since the time of the last inspection. However, not all contracts reviewed were found to be signed and agreed by the resident or their representative. The contracts included details about the support, care and welfare the resident would be expected to receive, details of the services to be provided and the fees to be charged for each individual resident had been calculated and was clearly stated by the provider.

However, additional fees payable for service provision were not specified. Some residents had personalised contracts of care and other residents had a generic version, the inspectors were informed that the contract of care was currently under review. One resident had requested an individualised agreement and was awaiting this document before signing. Support hours and staffing ratios were specified in the contracts of care but not linked to residents personal plan assessments, and referenced "specified times" where residents required one to one support.

The inspector reviewed the revised admission, transfer and discharge processes in place. Evidence that residents' admissions were largely determined on the basis of criteria in accordance with the current Statement of Purpose was found, and no new admissions had taken place since the last inspection.

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:

Overall residents were satisfied with their opportunities to participate in meaningful activity, appropriate to his or her interests. At the time of the last inspection there was an absence of appropriate personal plans with the involvement of each resident and/or their representative. Since the last inspection some improvements had taken place to the clinical documentation, and the work required was ongoing and the provider had an agreed time frame to complete this until 31 May 2015. The provider had partially addressed the non-compliance relating to personal plans highlighted at the time of the last inspection and had a plan to train and fully implement a new documentation system to support assessed care needs. However, inspectors noted that the system required further improvements to fully reflect each residents specific assessed individual needs and choices and the planned supports in place, and each individuals involvement.

Care plans reviewed by inspectors were generally in place with regard to wellbeing and identified healthcare needs. Inspectors confirmed that residents were fully supported from a social perspective and with the majority of their healthcare needs. The assessed social care supports were yet to be fully documented by support staff to reflect care provision. Although some residents and relatives had expressed a wish to be more involved with reviews and the personal plans. The active involvement of the majority of residents was not fully evidenced on the new documentation relating to their individual care supports in place. The person in charge confirmed that this aspect of the documentation required additional training for staff to fully complete each residents goal setting wishes and daily activity plans with resident involvement. This training was scheduled and a further two modules which fully informed staff would be completed before the end of May 2015 within the stated time frame agreed.

The inspector was satisfied that generally the care supports provided to the residents were appropriate to meet their assessed needs. Close links were maintained with regard to any residents attending day care services and communication took place as required.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The location, design and layout of the centre was found to be suitable to meet the current profile of residents' individual and collective needs in a comfortable way. Although some improvements were necessary. The centre commenced operating in 1974, as a two storey purpose built home and the inspectors were informed at the time of the last inspection that the process of de-congregation had begun. Residents used only the ground floor and extensive grounds set in park lands, which was located near the city centre and other amenities. The centre was originally designed to accommodate a larger number of residents on a long term basis. Reduction in numbers has created a smaller community which now accommodated 16 people in a more comfortable way. All rooms were single and contained hand washing facilities, bed, furniture including wardrobes, chairs and tables, with adequate storage for all residents. One bedrooms had en-suite facilities and two rooms were equipped with ceiling tracked hoists. Rooms were laid out in a male side and a female side and this accommodation was separate to the living, dining and office spaces. The centre was found to be warm and hygienic, with wide corridors and doorways for accessibility.

The building was in general well maintained, furniture fixtures and fittings were domestic in character. The décor of each residents room had been updated with support from the resident, relatives and the provider. A sofa in the main sitting room had bottomed out and required repair or replacement. Bedrooms size was adequate to meet each resident's individual requirements. However, one respondent to the questionnaire would have liked to put a sofa in their room. The dining area was bright, spacious and welcoming, and also had a nearby sun room.

The inspectors reviewed sanitary facilities and found sufficient communal bathroom and toilet facilities for all residents. Modern assistive equipment was readily available including moving and handling equipment. The residents had a laundry area they could access, but space around the machinery was limited and this area was not fully accessible to wheelchair users and requires review.

However, improvements were required relating to re-decoration, and evidence of

planning compliance had not been submitted as part of the application to register. A window in one of the bathrooms was identified as a hazard and requires further review as a number of the same type of windows were noted around the premises.

The corridors and communal areas also required some further decorative improvement to paintwork. A new landscaped garden area was shown to the inspector and a poly tunnel was in use where one resident was observed working with the gardener. The inspector noted that some improvements had taken place with regard to the external spaces and gardens, but further assessment of the pathways to ensure level access for wheelchair users was required around the building. The main driveway accessing the premises had a steep incline and was sign posted as requiring caution when entering the and exiting. Relatives in their questionnaires also high lighted this as a concern.

The assistive equipment was maintained in line with best practice, but no written records were maintained of checks made to bed frames which are completed by the in house maintenance staff.

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:

The provider had fully addressed the non-compliance relating to the emergency plan. Overall the health and safety of residents, visitors and staff was promoted and protected.

Staff had completed two fire drills since the last inspection and allocated a named daily fire warden, and had access to appropriate emergency equipment. Evidence of learning from each drill was communicated at staff and management meetings. For example, the use of the walkie talkie device to communicate had been clarified to ensure contact could be maintained between the fire warden and staff in case of emergency. Each resident had a detailed personal evacuation plan in place and means of escape were found to be clear and unobstructed. Fire drills have taken place at different times of day and a record maintained of how the evacuation or drill was managed.

All staff had completed fire training within the past year and both residents and staff spoken with had a clear understanding of the procedure to be followed in the event of a fire. The records reviewed showed that fire drills were practiced during the day, but not

at night time, and did not include any participation of residents.

The safety statement had been updated and the risk management policy was in place and systems to manage any identified risks clearly identified. The person in charge had access to the risk management/ health and safety co-ordinator for support and advice. The risk management policy includes all the requirements of the legislation and was found to be implemented at the time of the inspection. Risk assessments were in place for a small number of residents who smoked. However, incidents had been reported with regard to residents smoking in their rooms, which was contrary to the centres' own policy on smoking and this had not been addressed in a robust manner.

A fire safety record was available for inspection and demonstrated that drills took place during the day. Records were available to confirm that fire equipment including fire extinguishers, the fire blanket, emergency lighting and the sensors had all been tested by professionals within the required time frame. Written confirmation from a properly and suitably qualified person with experience in fire safety design and management that all statutory requirements relating to fire safety and building control have been complied with as required in the registration regulations had been provided to the Authority in line with registration legislative requirements.

The service manager had ensured that all three vehicles were taxed, insured and road worthy, one car, and two transit type accessible bus vehicles were available for taking residents to education, day service or on leisure outings.

Arrangements were in place for recording, and investigating serious incidents / adverse events. Serious incidents had been notified by the person in charge or notified in the quarterly returns by the person in charge to date. There was a good overall approach to risk at the centre. However, the documentation and use of the incident forms and description of incidents and actions taken following any adverse event requires improvement by all staff as outlined in Outcome 18.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

Measures were in place to protect and safeguard residents which included a policy and procedure on the prevention, detection and response to abuse. Staff had up to date mandatory safe guarding vulnerable adults training since the time of the last inspection and those spoken with had a clear understanding of how to safe guard residents'. The policy reviewed by the inspector clearly guided staff should it be necessary to respond to any allegation of abuse at the service. One complaint had been escalated by the provider and the investigation and review had not been completed. However, the inspectors were satisfied that a robust response had taken place by the person in charge and will review the final investigation report with an outcome when provided by the provider.

Residents confirmed to the inspector they felt safe living in the centre and valued their privacy. The residents living in the centre told the inspector the centre was a safe and secure home to live in. Residents had access to gardens and grounds, and the wider park environment. All the exit/entry doors could be secured by locking and there was a policy on locking up each evening. Residents could lock their bedroom door if they wished, and privacy and dignity was respected. The inspector saw bathroom and toilet doors had privacy locks and there were curtains and blinds in place on bedroom windows. Staff worked with residents to support their personal safety and safety awareness.

Communication between residents and staff was respectful. Individual preferences were respected. For example, residents who preferred that staff of a particular gender attend to their personal intimate care had this documented and implemented to their satisfaction.

Support with finances to enable independence was offered where appropriate and a full assessment took place by the person in charge and this was maintained in a confidential manner. A written policy guided this practice and evidence of a high standard of record keeping and administration was evidenced to the inspectors. Residents could readily access their funds on a daily basis to facilitate their lifestyle and activity.

A full review of any residents using bed rails and/or any restrictive practices had not taken place since the last inspection. The documentation was not fully in line with best practice and alternatives used prior to implementing the use of bed rails was not fully evidenced by the person in charge. The associated care plans did not fully describe the use of a bed rail as an enabler or otherwise to fully guide and inform all staff of the residents wishes. The rationale for a listening device used at night and alarms on a small number of wheelchairs in the grounds were not fully documented or reviewed appropriately. The person in charge confirmed this would take place in parallel with the new documentation system in use and report as required any restrictive practices in use at the centre.

Judgment:

Compliant

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

A record of incidents occurring in the designated centre was maintained and where required, notified to the chief inspector. A low level of incidents and accidents was confirmed and noted by the inspector. A system was in place to maintain any record of incidents and accidents occurring in the centre and was maintained by staff and monitored by the person in charge. However, improvements were required with regard to the systems in place to ensure all matters notifiable to the Chief Inspector are submitted by the person in charge as required by legislation.

Quarterly reports had been submitted to the chief inspector. However, as described in Outcome 8 a small number of restrictive practices confirmed on this inspection had not been properly submitted, and one complaint which had been escalated during 2014 had not been reported as a safeguarding allegation. A discussion was held with the person in charge regarding the specific restrictive practices which required reporting on, and the person in charge submitted the appropriate NF06 documentation following the inspection which was reviewed by the inspector.

One notification relating to a temporary loss of water at the service had been submitted late, the inspector requested further information and measures have been put in place with a temporary supply of water should this take place unexpectedly again. Other serious incidents' notifiable within three working days had been notified and further updates provided by the person in charge as requested in a timely manner.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Resident's opportunities for new experiences, social participation, education and training were facilitated and supported by staff. Some residents told inspectors that they exercised their right to change their planned daily activity, or not get involved with any group activity and reduced the number of days spent in day centre settings. Residents experiences included the following; attending day centre, training centre for people with neurological difficulties. Residents told the inspectors they liked to attend sport, leisure and football practice, listen to music and watch DVD's.

The person in charge confirmed that a number of residents' attended different training and education facilities during days per week. Each resident whether had their own weekly activity schedule which also included personal activity at the centre. Residents confirmed they enjoyed regular shopping trips, lunch outings, coffee and social clubs and attended day services. For example, a resident was going to Howth for a day out, other residents went out for lunch using the transport available from the centre (for which drivers and volunteers were available). Another resident had their own car as means of daily transport. Trips to the residents' homes or friends were facilitated and volunteers were actively involved with this aspect of daily life.

Residents were been facilitated to develop their areas of interest including information technology, gardening, cinema, sports and book club. The inspectors discussed with residents and staff and both confirmed that opportunities for day services, education and training opportunities had been explored and offered in the past as part of each residents review. Improvements in the documentation of each residents personal plan and records of their daily access to meaningful activities and development were required, and this was planned for.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

The inspector was satisfied that the non-compliance relating to training for staff in best practice guidelines in pressure ulcer prevention and gastrostomy care had been addressed by the providers. The current health care needs of residents were being met. The inspector reviewed a sample of residents' files and saw evidence that they were facilitated to access their General Practitioner and to seek appropriate treatment and therapies from health care professionals when required.

The inspector was satisfied that access to the allied health services was improving since the time of the last inspection to meet residents' needs. The physiotherapy service is provided and resident may access a defined number of sessions, and additional charges are in place if specialist therapies are required or specific physiotherapy treatment plans to maintain and improve function.

For example, inspectors were informed that plans were in place for the provision of a private dietician to undertake nutritional assessments for residents which has been facilitated. A private occupational therapist has also been sourced as there has been reported difficulty accessing a Health Services Executive service in the community for some residents who do not have established service links with other organisations providing this service.

Access to dental, chiropody and optician services are facilitated and available in the community for residents. Two residents attend the diabetic clinic at the local hospital and are monitored in line with best practice. The Authority was notified since the last inspection of residents with pressure ulcers requiring specialist treatment plans and referral. Inputs from the tissue viability nurse informed care planning and management in this area for staff. The person in charge was knowledgeable about each residents health care needs, but an individual written plan informing and guiding other staff was not consistently present in some residents records reviewed and this required further improvements. The person in charge undertook to address this at the time of the inspection.

The inspector saw that the care provided was not always documented in the resident's individual assessment and care planning records. However, this area of clinical documentation was progressing and had improved since the time of the last inspection. The inspectors were not satisfied that the gastrostomy care plan in place was evidence based and reflected best practice, and required further review to ensure safe practice was maintained, and to correctly inform and guide staff involved with this invasive procedure.

The designated catering staff facilitated mealtimes and most of the cooking in the main kitchen required for this. However, self-service was promoted, with accessible areas for residents to see and choose foods. The inspector saw that residents' had access to adequate quantities and a good variety of nutritious food to meet their dietary needs. Foods choices involved fresh fruits and vegetables, and alternatives were available. Snacks were available and staff all had up-to-date food hygiene training in place. Healthy choices were promoted and residents were facilitated to enjoy a balanced diet. Staff had a good knowledge of foods enjoyed by each resident and for any residents who required their food consistency modified. Residents confirmed that they were satisfied with the overall food service and choices available. However, the inspectors noted that during 2014 there had been issues raised and efforts made to address the concern and feedback from residents. The inspector confirmed with the person in charge that there had been no recent reports or complaints about food provision at the centre.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

The person in charge and provider had put in place robust improvements in medication management since the time of the last monitoring inspection. Prescription sheets had been revised to include route of administration and revised pharmacy support. There was a new medication management policy in place since the last inspection which included the ordering, prescribing, storing, administration and prescribing of medicines. The written policy described the assessment and ongoing supervision requirements for residents who wished to choose to self medicate, or do so with some staff support.

The inspector found that practices regarding drug administration and prescribing were now fully in line with best practice. Prescribed medications were individually signed and each medication chart contained the name of the resident GP. Administration procedures and documentation was safe and followed the written policy. Good practices were observed by the inspector during the inspection relating to staff members and the administration of medication. Training in the safe administration of medication had been provided to staff and staff maintained and signed the administration sheet. Generally, senior care support workers who had received the safe administration of medication training and competency assessment undertook this role on a daily basis.

The practices in relation to ordering, storing and disposal of medication were in line with the policy. There was a safe system in place for the ordering and disposal of medications and the inspector saw records which showed that all medications brought into and out of the centre were checked. An audit of each resident's medications was completed by staff; any discrepancies were identified and reported to the person in charge if required. The inspector was informed there had been no medication errors since the last inspection. There were good supports from the new pharmacy provider who supplied a pre-packed medication system. Staff did not currently check medication supplied by the pharmacist when delivered so any errors could be returned to pharmacy. The inspectors recommend that this practice is commenced to audit and ensure the high standard of medication management can be fully maintained. Pharmacy returns were documented and no out of date medication was found to be in use.

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 contained most of the information required by Regulations, and accurately described the services provided at the centre. The statement of purpose was written in a clear and accurate manner. Although some improvements in the document reviewed for registration purposes had taken place since the time of the last inspection further improvements were required;

- actual whole time equivalent nursing staff
- recent changes in regional management and organisational structure
- further details about team involved with de-congregation and aims and objectives
- room sizes and actual number of bedrooms
- accessibility of the premises

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):

No actions were required from the previous inspection.

Findings:

Improvements had taken place since the time of the last inspection. However, further improvements were required to reach compliance. The person in charge now had a deputy in place with the new service co-ordinator now in post. Both people provided leadership and guidance throughout a time of change and improvements. The inspector met with the person in charge and the service co-ordinator individually and reviewed their knowledge and understanding of regulation and fitness to provide a safe service. There was a clearly defined management structure that identified the lines of authority and accountability.

The centre was managed by a suitably qualified, skilled and experienced service manager with authority, accountability and responsibility for the provision of the service. She was the named person in charge, employed full time to manage the service in this role since January 2014. The inspector observed that the person in charge was involved in the governance, operational management and administration as the service manager. She is a qualified registered general nurse. She had a very good knowledge and understanding of the residents' who confirmed they knew her well.

During the inspection the person in charge demonstrated sufficient knowledge of the legislation and of her statutory responsibilities. Records confirmed that she was committed to her own professional development. She reported directly to the regional manager who has just come into post following the resignation of the last post-holder at the end of October 2014. Satisfactory interim arrangements were in place for another regional manager to support the person in charge which she reported. The inspector was informed by the person in charge, and saw evidence that regular scheduled minuted meetings took place with the regional manager.

Management systems were in place to ensure that the service provided were safe, appropriate to residents' needs, consistent and effectively monitored. However, further to the last inspection on 26 August 2014 improvements were required relating to the overall governance structure and supports in place to the person in charge. The inspector saw evidence that issues identified on the first inspection of the service had been addressed or partially addressed. Reviews undertaken by the service quality officer took place. A report given to the inspectors on inspection did not fully meet the

legislative requirements, in that this review was not fully informed by feedback from residents and relatives. The inspectors were informed that the methodology to inform an annual review of the service, was to be developed in an appropriate format by management.

As part of the application for registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). Documents relating to planning by the provider for the purposes of application to register were not submitted as required by current legislation.

Judgment:

Non Compliant - Moderate

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 Chief Inspector had not been notified of the proposed absence of the person in charge of the centre to date and the inspector was satisfied that arrangements were now in place for the management of the centre during her absence.

The service co-ordinator who was a qualified social care worker was nominated by the provider and worked full-time at the centre. The inspectors met and interviewed him and he clearly demonstrated good knowledge of residents' as individuals and he had the required experience and qualifications to manage the centre in the absence of the person in charge.

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):

No actions were required from the previous inspection.

Findings:

The centre was sufficiently resourced to ensure the effective delivery of care and support to residents' in accordance with the Statement of Purpose.

The resources available within the centre were appropriately managed by the person in charge to meet the needs of residents', and overall the person in charge ensured that there was enough staff allocated to the centre to meet the individual and collective needs of residents'. However, improvements were required relating to Outcome 17 and the skill mix and provision of adequate nursing care to meet the assessed health care needs of residents.

Judgment:

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:

Improvements had taken place since the time of the last inspection, but further improvements were required to address the identified non-compliances identified at the time of the last inspection. Training has been provided and was in progress relating to personal planning. The training relating to pressure ulcer management and gastrostomy care had been provided. The inspector confirmed with the person in charge and further to a review of staffing had taken place since the time of the last inspection. There had a

requirement to increase the number and hours worked by the nursing staff to facilitate the clinical supervision of assessed nursing needs. However, on this inspection the inspectors noted that there had been a decrease in the availability of nursing hours and one part time agency nurse worked 0.56 whole time equivalent hours. Additional improvements were in progress relating to the provision of a standard clinical audit programme relating to personal planning, restraint management, and medication management which is scheduled to be completed by the end of November 2015.

The person in charge confirmed that a recruitment process to employ a clinical nurse manager had been unsuccessful to date, and she had continued with efforts to employ a suitable nurse to increase nursing hours. The person in charge confirmed provision of additional nursing hours via agency provider when there was a requirement related to complex nursing needs of a number of residents. However, the current arrangements were not satisfactory provision relating to continuity of care for residents who required identified assessed nursing care. For example, management of urinary catheters, gastrostomy care, pressure ulcer prevention and management, bowel management, and supervision of medication management. Health care plans were not in place to support residents with new healthcare problems and changing care needs.

Staffing levels included the person in charge, service co-ordinator, one part-time agency staff nurse, senior care support workers, and care support workers. Unanticipated leave was covered in house or by use of an agency nurse or care staff. The person in charge had increased staff supervision arrangements, and the service co-ordinator had commenced since the time of the last inspection. Staff and skill mix required review particularly relating to the number of care support workers employed with relevant qualifications and accredited training. The inspectors acknowledge many staff working in the service have extensive years experience and have been offered formal training by the provider. This key area in learning and development needs to be addressed for staff to adequately provide for the assessed needs of all residents living at the centre.

The inspector reviewed staff training records and saw evidence that staff employed had mandatory training in place including fire, safeguarding and risk management training and those spoken with had a good knowledge of procedures to follow. In addition, staff involved with medication administration had completed Safe Administration of Medication training (SAMS).

There were four volunteers identified as working in the centre, and they lived above the centre in accommodation provided by the provider. The volunteers were rostered to work, with two volunteers available at weekends also.

The recruitment process was found to be safe and robust, staff files were fully reviewed on the most recent inspection on 26 August 2014 and all documents outlined in schedule 2 were available in each of the files reviewed.

Judgment:
Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

Overall the records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Residents and Adults) with Disabilities) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Other than the records referred to in Outcomes 5 and 11 relating to personal plans.

An insurance certificate was submitted as part of the registration pack and it showed that the centre was adequately insured against accidents or injury to residents, staff and visitors. Records viewed by inspectors also confirmed that the means of transport used by residents was adequately insured. There was a directory of residents available on a computerised system, but this did not contain all the required information, and was not easily accessible.

The centre had most of the written operational policies as outlined in schedule five available for review, further to the inspectors' review some improvements were required as outlined in Outcome 4 of this report relating to the written contract of care.

The person in charge also identified areas of policy provision to the inspector where there are ongoing works to address these matters by June 2015. The inspector acknowledges that the policy for admission, transfers and discharge of residents was in draft format.

As outlined in Outcome 17 the staffing rosters were not fully maintained to Schedule 4 requirements, and the names of the person in charge, service co-ordinator and agency staff covering unanticipated leave were not included in full.

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:

Leone Ewings
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003441
Date of Inspection:	07 April 2015
Date of response:	28 May 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The complainant was not informed promptly of the outcome of complaints in all cases, with details of the appeals process.

Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

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

a) In the specific instance identified by the inspectors, a formal investigation into the allegation has commenced (coordinated by the Regional Manager). All individuals concerned will be met with by the appointed investigation team. A discussion with all relevant individuals regarding the findings and outcomes of the investigation process will occur upon completion.

b) Cheshire Ireland has recently appointed the Service Quality Officer as the National Complaints Officer. Service Manager to discuss all complaints which progress to the preliminary enquiry stage with this person (and the Regional Manager) and seek advice at all stages of the process, including the provision of information to individuals regarding the outcomes of complaints raised.

c) The Service Quality Officer and Human Resources Business Partner are currently sourcing an external agency to provide training for senior staff around the management and investigation of complaints / allegations made to ensure all senior staff have the necessary skills to manage and investigate complaints.

d) A laminated easy to read version of the complaints procedure is on display in the entrance to the service. This document contains information regarding the appeals process and will be updated as required

a) Proposed Timescale: 31st June 2015

Responsible Individual(s): Regional Manager & Service Manager (in conjunction with the investigation team)

b) Proposed Timescale: On-going

Responsible Individual(s): Service Manager & Regional Manager (in consultation with Service Quality Officer)

c) Proposed Timescale: Training to be sourced and completed by 31st September 2015.

Responsible Individual(s): Service Quality Officer and Human Resources Business Partner (in consultation with Regional Manager)

d) Proposed Timescale: Completed.

Responsible Individual(s): Service Manager

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

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

The records maintained by the nominated person were not complete and did not include the outcome of the complaint, and any action taken on the foot of a complaint or whether or not the resident was satisfied.

Action Required:

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

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

All complaints logged in the electronic database by the Service Manager will be reviewed by the Regional Manager on a monthly basis to ensure comprehensive information regarding the outcome of complaints, actions required / taken following complaints logged and satisfaction with the outcome of each complaint is logged. The electronic database has been updated to contain a section for logging satisfaction / dissatisfaction with the outcome of each complaint.

Proposed Timescale: Commencing May 2015 & on-going.

Proposed Timescale: 31/05/2015**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no evidence in the records that residents had access to advocacy services or information for the purposes of making a complaint.

Action Required:

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

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

During the development of each persons' individualised personal plan, discussions regarding advocacy services and support available to access these services will take place with each resident. All individuals will have a completed comprehensive individualised personal plan in place by August 31st 2015.

Proposed Timescale: 31/08/2015**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The nominated person had not ensured that all complaints were appropriately responded to and records maintained as specified in the legislation.

Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person

nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

a) Cheshire Ireland has recently appointed the Service Quality Officer as the National Complaints Officer. Service Manager to discuss all complaints which progress to the preliminary enquiry stage with this person (and the Regional Manager) and seek advice at all stages of the process, including the provision of information to individuals regarding the outcomes of complaints raised.

b) The Service Quality Officer and Human Resources Business Partner are currently sourcing an external agency to provide training for senior staff around the management and investigation of complaints / allegations made to ensure all senior staff have the necessary skills to manage and investigate complaints.

c) All complaints logged in the electronic database by the Service Manager will be reviewed by the Regional Manager on a monthly basis

a) Proposed Timescale: On-going

Responsible Individual(s): Service Manager & Regional Manager (in consultation with Service Quality Officer)

b) Proposed Timescale: Training to be sourced and completed by 31st September 2015.

Responsible Individual(s): Service Quality Officer and Human Resources Business Partner (in consultation with Regional Manager)

c) Proposed Timescale: Commencing May 2015 & on-going.

Responsible Individual(s): Regional Manager & Service Manager

Proposed Timescale: 30/09/2015

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:

A number of contracts reviewed were found not to be signed and agreed by the resident or their representative.

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:

All Service Agreements to be reviewed and individualised to each person's service. This process will be carried out through discussions with the residents and / or their representative and upon agreement and completion, each service agreement to be signed by the resident or their representative

Proposed Timescale: 31/08/2015

Theme: Effective Services

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

Additional charges were not fully outlined in the contract of care, and support hours not specified.

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:

All Service Agreements to be reviewed and individualised to each person's service (and will include information regarding charges and support hours). This process will be carried out through discussions with the residents and / or their representative and upon agreement and completion, each service agreement to be signed by the resident or their representative

Proposed Timescale: 31/08/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

All residents did not have a comprehensive personal plan which reflected the involvement of the resident and personal goal setting.

Action Required:

Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, 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:

All residents are currently undergoing a comprehensive needs assessment by trained care support staff, overseen by the Service Co-ordinator and Service Manager.

Training will be provided to care support staff in the assessment and development of personal plans (including social plans) by the clinical support service team. Training in assessment will be provided the remaining staff team in on the following dates:

- 10 staff will be trained on 17th June 2015

Group 1 will receive final support session on personal plans (inc. social) 22nd June 2015
Group 2 will receive final support sessions on personal plans (inc. social) 29th June 2015

A Personal Plan will be completed for each resident by 31st August 2015.

The individual needs assessment will inform the development of each resident Personal Plan. The Service Manager, Service Co-ordinator & CNM1 (when in place) will supervise the assigned care support staff to develop each individual personal plan, with the support of the Clinical Services Support Team.

This plan will be reviewed on an annual basis or as required.

Proposed Timescale: 31/08/2015

Theme: Effective Services

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

All residents did not all have access to their personal plan in an accessible format.

Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

During the process of personal planning, accessibility to personal plans, and accessible format options, will be discussed with the resident in line with their preferred choice and support need. If further support is required from external service providers (e.g. the SLT / NCBI etc.) to provide a more specialist accessible format, the completion date may surpass 31st of August 2015 but will be addressed as a matter of priority.

Proposed Timescale: 31/08/2015

Theme: Effective Services

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

The evidence of each residents involvement in creating personal plans was not found.

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:

All care support staff supporting residents with their personal plans must be provided with a refresher session on the 'Cheshire Ireland Guidelines on developing and implementing best possible health assessments and care plans'.

Each resident will be included in all aspects of personal plan discussion and writing, and will sign off on their own plan as each area is complete.

Proposed Timescale: 31/08/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Laundry room for residents is small and not fully accessible to all.

Action Required:

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

An alternative laundry room has been identified within the building and fitted with all appliances necessary to enable residents to do their own laundry (if they so wish). This room has adequate space and be fully accessible.

Proposed Timescale: 28/05/2015

Theme: Effective Services

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

The pathways external to the premises require review and minor repairs or replacement to allow for residents safety.

Action Required:

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

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

CE participants (staff), in conjunction with Cheshire Ireland staff will address all areas

of internal external repair which have been identified as requiring replacement renovation and / or repair / maintenance. This will ensure the building and external pathways are aesthetically pleasing, in a good state of repair, safe and accessible for all residents.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Internal maintenance programme for painting and minor repairs to ceilings, walls and architrave not up to date.

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:

a) CE participants (staff), in conjunction with Cheshire Ireland staff are have identified all areas requiring painting and all repairs required to ceilings, walls and architrave. These repairs and painting requirements will be completed by 31st June 2015.

b) An internal programme of on-going maintenance and repair will be developed for the service to ensure the continued upkeep / maintenance of the building and external grounds

a) Proposed Timescale: 31st June 2015

Responsible Individual(s): Service Manager, Service Co-ordinator & CE Supervisor

b) Proposed Timescale: Programme to be developed by 15th June 2015 & on-going

Responsible Individual(s): CE Supervisor

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Accessibility of driveway and entrance avenue requires review.

Action Required:

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

CE participants (staff) are currently in the process of ensuring the driveway and entrance are clear of obstruction, maintained and pot holes are filled / covered.

While the gradient of the external driveway cannot be altered, a risk assessment will be carried out to ensure the safety of residents entering and exiting the service independently and control measures are implemented if identified. The actions above will ensure the driveway is maintained as safe as possible and to ensure ease of access / egress.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Windows in bathroom and elsewhere in premises require review to ensure suitable for residents use.

Action Required:

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

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

All windows within the service have been assessed. Any areas of risk which have been identified are being addressed to ensure their safety and suitability for use

Proposed Timescale: 30/06/2015

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:

Risks associated with residents smoking in their own bedrooms contrary to the smoking policy had not been mitigated or documented fully.

Action Required:

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

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

A review of the risk assessments in place to be carried out for all residents who choose to smoke in their rooms to ensure each assessment is comprehensive, appropriate to the individual and in line with Cheshire Ireland's smoking policy.

Proposed Timescale: 15/06/2015

Theme: Effective Services

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

Fire drills did not taken place out of hours to include staff working in limited numbers.

Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

A regular and on-going schedule of fire drills (including out of hours fire drills) has been developed and implemented / rolled out within the service

Proposed Timescale: Regular schedule developed & on-going

Responsible Individual(s): Service Manager & Service Co-ordinator

Proposed Timescale: 28/05/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Restrictive environmental and listening measures not fully assessed and reviewed or documented in accordance with national policy and evidence based practice.

Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

A review of all current restrictive practices within the service to be carried out to ensure they have been identified and assessed, are in line with national policy and best practice and have the appropriate comprehensive documentation in place.

These will be detailed in individual's personal plans

Proposed Timescale: 31/08/2015

Theme: Safe Services

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

The final report on a matter which was escalated as part of a complaints process was not completed on the date of the inspection.

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 the specific instance identified by the inspectors, a formal investigation into the allegation has commenced (co-ordinated by the Regional Manager). All individuals concerned will be met with by the appointed investigation team. A discussion with all relevant individuals regarding the findings and outcomes of the investigation process will occur upon completion.

Proposed Timescale: 30/06/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

A complaint which was escalated by the provider to a safeguarding issue was not notified as required to the Authority.

Action Required:

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

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

While the incident was notified to the Authority as an NF03 (as this was the original issue reported), the matter progressed to a safeguarding issue and a subsequent NF06 was not submitted.

Regional Manager to be informed of all safeguarding issues / allegations of abuse.

Appropriate notification form to be filled out by the Service Manager and forwarded to the Regional Manager and Service Quality Officer for submission to HIQA within 3 days.

Proposed Timescale: 28/05/2015

Theme: Safe Services

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

Loss of water not notified within three working days.

Action Required:

Under Regulation 31 (1) (c) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.

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

Meeting between Service Manager, Regional Manager and Service Quality Officer to be held to discuss all categories of notifiable events and criteria for same.

HIQA guidance document on notifiable events to be discussed within staff meetings on a regular basis and a copy to be placed in staff room.

Appropriate notification form to be filled out by the Service Manager and forwarded to the Regional Manager and Service Quality Officer for submission to HIQA within 3 days.

Proposed Timescale: 28/05/2015

Theme: Safe Services

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

Restrictive practices not reported as required on a three monthly basis.

Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

A review of all current restrictive practices within the service to be carried out to ensure they have been identified and assessed and are included in the quarterly notification returns submitted to HIQA (on a 3 monthly basis)

These will be in personal plans

Proposed Timescale: 31st June 2015 & on-going each quarter.

Proposed Timescale: 30/06/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Personal plans in place for gastrostomy care was not fully evidence based, or in concordance with specialist advice and required review.

Action Required:

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

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

Advice was sought from a specialist dietician and amendments were made to current practice and the individual's personal plan to ensure care is evidence based and best practice. All staff have been informed and instructed on the change in practice

Proposed Timescale: 28/05/2015

Theme: Health and Development

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

Health care plans were not in place for residents with newly identified health care needs.

Action Required:

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

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

The CNM1 will develop healthcare plans with each resident and their key worker. These plans will be place in each individual's personal plan in an accessible format. Also the CNM 1 will provide clinical supervision to all care support staff. All plans will be reviewed by the CNM 1 and the Regional Clinical Educational Facilitator at least every 6 months to review individual's personal plans and any changes healthcare needs will be documented and updated in individuals plans as required.

Proposed Timescale: 31/08/2015

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:

Improvements were required to accurately reflect service provision at the designated centre in the statement of purpose;

- actual whole time equivalent nursing staff
- recent changes in regional management and organisational structure
- further details about team involved with de-congregation and aims and objectives
- room sizes and actual number of bedrooms
- accessibility of the premises

Action Required:

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

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

A review of the current Statement of Purpose to take place to ensure it contains comprehensive information regarding:

- actual whole time equivalent nursing staff
- recent changes in regional management and organisational structure
- further details about team involved with de-congregation and aims and objectives
- room sizes and actual number of bedrooms
- accessibility of the premises

Proposed Timescale: 30/06/2015

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 evidence of compliance with planning legislation has not been received for registration purposes.

Action Required:

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

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

All attempts / efforts to obtain this document for the service have been exhausted. Documentation (e.g. e-mails) outlining the efforts to obtain this document (to no avail)

can be provided to the Authority if required.

Cheshire Ireland received a letter form HIQA on 19th February stating:

“Applications that have been submitted without all the above-mentioned documentation will be processed up to the point of proposed decision and then after 1st March 2015, assuming all else is in order, a notice of proposal will be issued”.

Cheshire Ireland are optimistic that “all else is in order”

Proposed Timescale: 28/05/2015

Theme: Leadership, Governance and Management

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

The provider had not completed an annual review of quality and safety and support provided at the designated centre.

Action Required:

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

A review of the quality, safety and support provided at the designated centre was carried out by the Service Quality Officer on 31st March 2015; however an action plan based on this review had not been developed at the time of the inspection.

A schedule of quality reviews for 2015 / 2016 will be developed for Cheshire Irelands 17 designated centres throughout the organisation (including Cara Cheshire Home). This will be developed by 31st June 2015.

A quality and safety audit will be carried out in Cara Cheshire Home annually and a report will be produced by the auditor (who will be a member of staff external to Cara Cheshire Home) outlining areas of good practice and opportunities for improvement. This report will be reviewed and approved by the Registered Provider prior to its circulation to the Service Manager and relevant individuals. Following this an action plan will be developed by the Service Manager and Service Co-ordinator (in conjunction with the Regional Manager and Service Quality Officer) to ensure all areas of non-compliance are addressed. Progress around meeting the actions required will be monitored by the Service Quality Officer / Registered Provider.

Proposed Timescale: 30/06/2015

Outcome 17: Workforce**Theme:** Responsive Workforce**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents with assessed nursing care needs was not provided at all times due to the reduction in nursing hours since the time of the last inspection.

Action Required:

Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

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

A full time (39 hours per week) Clinical Nurse Manager I has recently been recruited to fill the vacant post and is due to commence employment by 31st June 2015. This increase in nursing hours within the service will ensure that all residents with assessed nursing care needs will receive the appropriate nursing care at the time required.

Proposed Timescale: 30/06/2015**Theme:** Responsive Workforce**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The skill mix of staff available to meet the changing health and social care needs and supervise appropriately was not adequate at all times or in line with the statement of purpose or application to register.

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 recently recruited Clinical Nurse Manager I (in conjunction with the Service Manager, Service Co-ordinator and support from Cheshire Ireland's Heads of Functions) will support, develop, mentor and supervise Care Support staff within the service to ensure they are adequately equipped to meet the changing health and social care needs of all residents. One to one meetings will occur with care support staff on a 6 – 8 weekly basis to ensure mentorship is provided and training needs are identified

Proposed Timescale: 30/06/2015**Theme:** Responsive Workforce

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

Staffing competencies had not been reviewed to ensure that a continuous professional development programme was in place to adequately inform and guide staff in an evidence based manner.

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:

A comprehensive Care Staff Learning Needs Analysis is undertaken by the National Learning and Development Manager with the Regional Management team, Head of Quality, Head of Clinical Support Services, National Risk Manager, National Health & Safety Officer and Service Quality Officer with responsibility for HIQA registration. This review is carried out on an annual basis and combined with the data from our national Training Database, a comprehensive and specific training plan is put in place for each service throughout the country. This plan highlights the areas of training in which each staff member must participate throughout the year. This covers both first time participants and those staff who need to refresh their training. This plan is then discussed by the National Learning and Development Manager with each Service Manager and with the relevant Regional Manager, and is reviewed on a quarterly basis to ensure that it is being actioned as planned. Should any new/unforeseen training needs arise e.g.: a service user develops a new care support which demands that staff be upskilled, then this need is brought to the attention of the National Learning & Development Manager and training is provided accordingly. In this way Cheshire Ireland ensures that staff are facilitated to receive appropriate training as part of their continuous professional development programme.

Proposed Timescale: 28/05/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Policy for admission, transfer and discharge of residents was not finalised and had not been implemented.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:

Draft policy to be agreed and signed off by the Senior management team at the next scheduled meeting

Proposed Timescale: 30/06/2015

Theme: Use of Information

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

The directory of residents was not available in the required format or in line with regulatory requirements.

Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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:

a) There is a national "service user database" in existence in the organisation, however there are elements outlined in the regulations that are not included in the database in its current format. This national database will be reviewed and revised to ensure it meets all regulatory requirements. The database will be monitored on an on-going basis to ensure accuracy of information.

b) A working group including the Service Manager, CNMI, & Regional Clinical Educational Facilitator will meet to review the local content and process around supporting the collation and input of data into the Service User Database. This working group will identify the areas which require change and develop a plan to implement these changes by 30th June 2015.

The required changes to the database will be completed by July 31st and the database will be monitored on an on-going basis to ensure the accuracy of the information contained within.

a) Proposed Timescale: 31st December 2015

Responsible Individual(s): Senior Management Team

b) Proposed Timescale : Revised database to be completed by 31st July 2015

Responsible Individual (s): Service Manager , CNM 1 & Regional Clinical Educational Facilitator

Proposed Timescale: 31/12/2015

Theme: Use of Information

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

the following respect:

The staffing rosters did not include a record of the hours worked by the person in charge and service co-ordinator on the actual staff roster on the day of the inspection in line with Schedule 4 requirements.

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:

Staffing rosters now include a record of the hours worked by the Service Manager and Service Co-ordinator

Proposed Timescale: 28/05/2015**Theme:** Use of Information**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staffing rosters reviewed did not include the full names of agency staff on the roster who provide temporary cover for unanticipated absences.

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:

Staffing rosters now include the full names of agency staff on the roster who provide temporary cover for unanticipated absences.

Proposed Timescale: 28/05/2015