

**Health Information and Quality Authority  
Regulation Directorate**

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



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| <b>Centre name:</b>                                   | A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland |
| <b>Centre ID:</b>                                     | OSV-0003439   |
| <b>Centre county:</b>                                 | Cork  |
| <b>Type of centre:</b>                                | Health Act 2004 Section 39 Assistance   |
| <b>Registered provider:</b>                           | The Cheshire Foundation in Ireland  |
| <b>Provider Nominee:</b>                              | Mark Blake-Knox   |
| <b>Lead inspector:</b>                                | Mary O'Mahony   |
| <b>Support inspector(s):</b>                          | Louisa Power;Noelle Neville   |
| <b>Type of inspection</b>                             | Unannounced   |
| <b>Number of residents on the date of inspection:</b> | 21  |
| <b>Number of vacancies on the date of inspection:</b> | 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 04 December 2015 07:00 To: 04 December 2015 17:00

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

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| Outcome 01: Residents Rights, Dignity and Consultation            |
| Outcome 02: Communication   |
| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs                                     |
| Outcome 06: Safe and suitable premises                            |
| Outcome 07: Health and Safety and Risk Management                 |
| Outcome 08: Safeguarding and Safety                               |
| Outcome 09: Notification of Incidents                             |
| Outcome 11. Healthcare Needs                                      |
| Outcome 12. Medication Management                                 |
| Outcome 13: Statement of Purpose                                  |
| Outcome 14: Governance and Management                             |
| Outcome 16: Use of Resources                                      |
| Outcome 17: Workforce   |
| Outcome 18: Records and documentation                             |

**Summary of findings from this inspection**

HIQA undertook a series of inspections of centres operated by Cheshire Foundation Ireland during 2015 and found a high level of non-compliances with the requirements of the regulations and the National Standards. In particular, inspectors found that the provider did not have adequate governance arrangements to ensure a safe and good quality of service for residents. The provider was required to attend a meeting with HIQA on 25 November and at that meeting, the provider told inspectors of a plan to reconfigure governance arrangements, improve support for local managers and address the areas of non-compliance in each centre. Since that meeting, while there continues to be non-compliances, HIQA has seen evidence that the provider is implementing their actions to improve the services. Inspectors will continue to monitor these centres to ensure that the improvements are sustained.

This was a follow up inspection of this centre and was unannounced. As part of the

inspection inspectors met with residents, the person in charge, the quality manager, and other staff members. Inspectors reviewed the policies and procedures in the centre and reviewed documentation in relation to aspects of care such as, medication management, complaints, safeguarding and safety, personal plans, staff files, fire safety management records and the training matrix. Inspectors found that since the last inspection there was a good level of improvement in the centre. Most of the action plans submitted to the Authority following that inspection had been completed.

The centre was comprised of a large period style house which could accommodate eight residents, nine self-contained apartments and one house where four residents, who had transitioned from the main house, now resided. There were adequate parking spaces in the front and back of the building. Inspectors observed that there were minibuses parked in the car park, which were available for use by all residents. Residents were also seen to be collected and brought back to the centre by other relevant, supporting services, during the day.

The person in charge was responsible for the management of all three areas of the centre which was a change from the management structure in place on the previous inspection where there had been three persons in charge.

During the inspection there were 20 full-time residents in the centre and one respite resident. While the inspection was in progress the residents were seen to attend various day care and work arrangements.

The action plan at the end of the report identifies areas where improvements were needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities. Some areas which were not in compliance with the aforementioned Regulations were: medication management, workforce, health and safety and contracts for residents.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

There was a regular consultation process in place in the centre. The named advocate's contact details were displayed on a notice board in the hallway along with the complaints procedure. The person in charge informed inspectors that regular resident meetings as well as meetings with individual residents were facilitated. Concerns and complaints were documented and followed up. Records to support this were viewed by inspectors.

Residents with whom inspectors spoke confirmed that meetings took place. A folder containing accessible documents was visibly displayed in the hallway of each area. This included information on how to make a complaint, residents' rights, access to advocacy, the Resident's Guide and the statement of purpose. There was pictorial input in the documents also.

Staff with whom inspectors spoke were aware of residents' routine and abilities. The staff roster was available for viewing by inspectors and this indicated that more than 40 staff worked to support residents in the centre. The provider had developed policies to guide staff on the care of residents' property and money management, as required by Regulations. The person in charge informed inspectors that personal belongings were listed and signed by the resident. Consent forms were signed for medication administration, photographs where required and financial transactions. This documentation was reviewed by inspectors.

Activities within the centre were now readily available as the activities room had been made available for use by residents. Residents with whom inspectors spoke were very

happy with this as they could now congregate sociably with residents from the apartments and the smaller house. External agencies no longer utilised the centres' facilities as they had relocated back to their own, newly renovated centre. In addition, the internal garden area was now freely available to residents.

There was access for residents to local amenities. Day trips and overnight outings as well as family holidays, which were in line with individual assessed needs, were arranged. Residents had access to personal transport, taxis and minibuses. Residents with whom inspectors spoke indicated that availability of transport and accessibility to outings had improved since the previous inspection. Staff informed inspectors that extra staff members had been employed to accompany residents on outings, doctor's appointments and shopping trips. The centre received support from a variety of relevant organisations, local colleges and workplaces and a number of residents were seen to avail of these on a daily basis.

The centre had nine apartments and each had a bedroom, kitchen/dining and en suite facility. These were wheelchair accessible. There were large wardrobes, shelving and locked storage facilities available for each resident. Residents in both the house and apartments informed inspectors that they had been consulted about décor and relevant adaptations prior to any renovations which had taken place. Minutes of meetings confirmed that these discussions had taken place.

**Judgment:**  
Compliant

## **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):**

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

### **Findings:**

Inspectors noted that residents had access to appropriate media, such as television, radio, and assistive technology. Residents had 'tablets' also with internet availability.

There was a communication policy in the centre which had been reviewed in June 2015 and was found to be comprehensive. During the inspection, staff who spoke with inspectors demonstrated awareness of the individual communication needs of residents. Staff outlined the systems that were in place to meet the diverse communication needs of residents. In addition, inspectors noted that individual communication passports were present in residents' personal plans which indicated what type of behaviours the residents might display to express their feelings. Pictures were also used for some

residents to aid communication for activities and tasks.

Staff, however, did not have training in communication strategies relevant to their role and the assessed needs of residents. This was significant as a number of residents could not communicate verbally. The provider had indicated in the action plan following the previous inspection, that this training would be afforded to staff on 23 December 2015. This issue was addressed under outcome 17: Workforce.

**Judgment:**

Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

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

**Theme:**

Effective Services

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

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

**Findings:**

There was an admissions policy in the centre dated June 2015. This admissions policy included the procedures for transfers, discharges and the temporary absence of residents. Since the previous inspection the policy had been updated to take account of the need to protect residents from abuse from their peers, as required by the regulations.

Inspectors noted that residents now had a written agreement of the terms on which they resided in the centre provided to them, as required by the regulations. There were seen to be signed by the resident or their representatives where appropriate. There was documentary evidence in the contracts that the contents had been discussed with residents. However, the fees for services were not set out for residents and the contracts lacked sufficient detail as to the supports provided to residents. In addition, there was a lack of clarity of the type of contract available to each resident. The provider undertook to review contracts.

**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):**

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

**Findings:**

Residents were facilitated to maintain maximum independence and to participate in meaningful events. Inspectors were informed by residents and staff that there were a number of options available to them in relation to activities and work. Life skills training was being facilitated for some residents and inspectors noted that residents were fully involved in their own daily routine which included cooking, laundry and shopping where possible. Inspectors spoke with residents throughout the inspection and they outlined their overall positive experience of living in the centre.

Residents spoke with inspectors about a number of off-site activities they enjoyed as outlined under Outcome 1: Residents' rights, dignity and consultation. Other residents spoke with inspectors about how they enjoyed relaxing at the end of the day; sometimes cooking their evening meal or watching television and listening to music.

There was a good supply of board games, CDs, books and DVDs on offer in the communal sitting room and in the residents' own apartments, house and bedrooms. Bedrooms were seen to be personalised with furniture, pictures and photographs. Residents showed inspectors their personal selection of books and trophies, as well as their music centres and televisions. The bedrooms were furnished with good quality furniture and residents informed inspectors that they could receive unrestricted visits.

The person in charge showed inspectors a number of the person centred plans (PCPs) in place for residents and it was evident that residents had been consulted in relation to the content of this documentation. Residents were able to access their personal plans at any time. Inspectors viewed evidence that residents had access to allied health services such as the dietician, physiotherapist, occupational therapist, dentist and the general practitioner. They were supported in their physical care by the care coordinators and care support staff. Each resident had a 'portable medical profile plan' prepared in their file. PCPs were seen to be implemented. Inspectors were informed by residents that staff were aware of and supported their personal goals where possible. There was evidence that the PCPs were reviewed regularly. Some residents had completed an 'advanced wishes' end-of life care plan and this was reviewed on a regular basis. There was an emphasis on promoting autonomy and some residents stayed out in a family member's home at weekends or had travelled abroad with family for holidays.

The centre housed the offices of two community transition staff who supported those residents who were moving to a different care setting or residents who intended to



move to a community setting. Transition plans were comprehensive and the transition coordinators were familiar with residents' needs and different abilities, when spoken with by inspectors.

Residents expressed their satisfaction at the restoration of the 'activities room'. The person in charge explained that a more extensive activity programme was in place and evidence of individual consultations re choice of activities was viewed by inspectors. This room was suitably decorated in preparation for Christmas. It was evident that residents had been involved in arts and crafts work during the week as their handiwork was on display in the centre and unfinished items were placed on the communal work table. In this room there was a library corner, an activities area, and a kitchenette. Each area was furnished and divided to allow for the separation of functions. In particular the library area was impressive as there was a 'stove-like' electric fire and a varied selection of interesting books available.

**Judgment:**  
Compliant

#### **Outcome 06: Safe and suitable premises**

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

**Theme:**  
Effective Services

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

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

#### **Findings:**

As described in the introduction to this report there were three distinct areas of care in the centre: the main 'period style' house, the apartment complex and the four-bedded house. The garden areas were well maintained and the centre had the services of a maintenance man who attended promptly to any repairs and faults identified. The apartments were colourful and very well maintained both inside and outside and the four bedded house was modern and appropriately decorated.

The large period style house was comfortable, spacious and clean. However, as found on the previous inspection the external walls of this house required painting. The person in charge informed inspectors that quotations for this work were being sought at present. Documentation confirming this was seen by inspectors. The kitchen of the centre was located in this basement. There had been improvements in this area since the previous inspection. It had been newly painted and was tidy and clean. Plans were seen for the refurbishment of the two small food preparation rooms in this area. The main kitchen was furnished with stainless steel cabinets and was seen to be well stocked

and clean. The person in charge showed inspectors a feasibility study which had been carried out in relation to moving the kitchen to a different floor. This was assessed as unnecessary and a suitably qualified person had assessed that the location of the kitchen did not present a fire hazard. Access to the basement area and to the car park area had been risk assessed in the context of the safety needs of residents. Risks had been mitigated and controls put in place to minimise remaining risks.

The upper floor of the main house was no longer in use. The area of the house in use for residents was located on the ground floor. There were now eight single bedrooms available for residents' use. The accommodation for residents was laid out in two corridors of bedrooms, where seven full time and one respite resident were accommodated. The two remaining corridors were used at present as office space. There were eight toilets in this section, as well as four shower rooms. There were large communal rooms available for relaxation, for activities and for dining. These 'period style' rooms were spacious and impressive in their design and décor. Extensive work on fire management systems in the main house had been undertaken since the previous inspection and this was discussed further under Outcome 7: Health and Safety and Risk management.

There were nine self contained apartments on the grounds of the centre which accommodated residents of low to medium dependency levels. The apartments were accessible from an individual front door for each resident and inspectors observed that these apartments also had back doors which led out to the patio areas. Inspectors were invited to view the interior of these apartments by some residents. They were modern and well maintained. Inspectors observed that they were equipped with assistive devices and appropriate furniture for the needs of residents. Residents who utilised wheelchairs for mobility reasons were also accommodated in these apartments. Residents demonstrated to inspectors that there were adjustable worktops and cupboards fitted to accommodate their needs. Residents spoke with inspectors about the fact that they were consulted by staff when their apartment was being decorated. Residents availed for the main house for social, dining and communal activities when they choose to do so.

The four-bedded detached house was home to four residents. They had individual bedroom accommodation which was suitably decorated and personalised. Inspectors met a number of residents in this house who stated that they were constantly developing new life skills. One resident informed inspectors that he had begun writing books. Residents informed inspectors that they prepared meals independently and attended to their personal laundry. These residents had been assessed as having varying dependency levels. A number of these residents were hoping to move to a setting in the community, in the future. There was a small patio area attached to this house. However, two residents in this house had been assessed as having high needs and the person in charge was asked to continue to review the night time staffing levels which had been discussed at the previous inspection. Evidence of related ongoing review and updated risk assessments were seen by inspectors. This issue was addressed under Outcome 7: Health and safety and risk management. Night staff informed inspectors that they would be required to go over to the house two or three times a night to attend to residents' needs. There was a nurse on call each night and the person in charge stated that this person was available to come in to the centre if there was an

emergency or if a resident was unwell.

**Judgment:**

Substantially Compliant

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

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

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

**Findings:**

The centre had a health and safety statement and it was relevant to the centre. There was a health and safety committee which met on a monthly basis and inspectors viewed the minutes of these meetings. There was a monthly audit of health and safety issues in the centre. A copy of this was provided to inspectors.

Procedures were in place for the prevention and control of infection. Alcohol hand gels and disposable gloves were available. The centre had a risk management policy and a risk register which identified potential risks (environmental, operational and clinical) associated with the centre. There were measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents. Staff informed inspectors that incidents and adverse events were also discussed at staff meetings. Inspectors viewed minutes of these meetings. Inspectors noted that incidents in the adverse incident record were recorded in detail. The process of learning from these events was clearly recorded and the outcome was documented.

As residents in the apartments and in the four bedded house relied predominantly on the personal call system operating correctly, risk assessment for this system had been updated and controls were now in place for regular audit and servicing of the system. Inspectors observed one resident using the call system and staff were seen to attend in a timely manner to the resident. As highlighted on the previous inspection there were no dedicated staff on duty after 22.00hrs in the apartments and in the four bedded house. However, the person in charge provided documentation to inspectors that two-hourly night time checks of the apartments and house were now undertaken by night staff, in addition to responding to call bells as required. This documentation however, was incomplete and there were approximately eight gaps noted in the recording of these night time checks, in the sample of records checked, from November 2015.

Inspectors viewed incidents where residents had fallen in the apartments and prompt attention had been provided according to the records seen. Audit of residents' compliance with wearing their personalised call system was done on a daily basis and response times to calls were acceptable. In addition, three residents who were not

physically able to use the call bell system were now checked nightly on a half-hour basis according to night staff spoken with by inspectors. However, none of these checks had been documented. The person in charge was requested by inspectors to ensure that such documentation was maintained to mitigate the risk to these very vulnerable residents.

An emergency plan was in place and a safe placement of residents in the event of an evacuation had been identified. Regular fire drill training was documented and there were personal evacuation plans for residents. Records reviewed by inspectors indicated that the fire alarm was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. The fire assembly points were identified and there was appropriate emergency lighting in place. There was evidence that arrangements were in place for daily checking of fire precautions which included the alarm panel, the fire exits, and the testing of fire equipment. However, inspectors noted some gaps in the night-time checklists of door closures, designated fire doors required to be closed and of window closures. Inspectors noted that fire exits were unobstructed. Staff, spoken with by inspectors, were aware of what to do in the event of a fire. The procedure was also displayed in both hallways to increase awareness. Residents had personal fire evacuation and emergency plans (PEEPS) available. In addition, a resident in one apartment was a smoker and the risk assessment in relation to his smoking habits was seen to have been updated. Fire safety management systems in this apartment included the provision of fire retardant furnishing and bedding. Work on installing required fire doors had progressed satisfactorily and these were in place at the time of inspection. The person in charge stated that she was waiting for the relevant door closures to be installed this week. She stated that the required upgrade work would then have been completed, in line with the advice from their suitably qualified person. Certification as to the suitability of the fire management system would then be made available to the Authority.

As mentioned in Outcome 12: Medication management, there was a system in place to identify, record, investigate and learn from medication related incidents. The medication related incident reporting forms indicated that similar incidents being repeated. The repetitive nature of this risk had not been assessed and steps had not been taken to minimise potential harm.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

The person in charge informed inspectors that she was actively involved in the management of the centre. There was a policy on the management of allegations of abuse. A copy of the Health Services Executive (HSE) policy on 'Safeguarding Vulnerable Persons at Risk of Abuse' 2014 was available. Notifications of any allegations of abuse were now progressed in line with the guidelines contained in the policy. Evidence of this was seen by inspectors in the details of notifications received by the Authority and in residents' files, where safeguarding plans were seen to have been developed when appropriate. However, a number of staff spoken with by inspectors stated that they had not been made aware of this HSE policy. This policy was widely circulated to all staff while inspectors were on the premises. In addition, the person in charge stated that she had spoken to the relevant trainer who informed her that this HSE policy was discussed in all related staff training sessions. All staff were trained in the prevention and recognition of abuse and safeguarding vulnerable adults at risk of abuse.

Residents said they felt safe in the centre and this was attributed to the fact that they were familiar with the staff and their personal assistants (P.A.). Inspectors spoke with the person in charge about the provision of training in the prevention of elder abuse and the protection of vulnerable adults. The person in charge stated that since previous inspections this training was now provided on a yearly basis. Additional staff training and supervision was discussed with the person in charge and improvements were noted as a result. For example, there were less complaints from residents about poor staff interactions and about the lack of response to care requests. Relevant notifications had been made to the Authority in relation to these events. In addition, records seen by inspectors confirmed that training in positive behaviour support and in behaviours that challenge had been made available for staff. However, there were a small number of staff who still required training. Inspectors were informed that this was scheduled. The centre now had a policy on positive behaviour support, which was required under Schedule 5 of the Regulations.

The centre had a policy on restrictive interventions which was dated 1 May 2015. Since the previous inspection, notifications of restraint in the form of bedrails and lap belts, had been made to the Authority, in line with the regulations. In addition, a restraint log was maintained in the centre to record the use of any form of restraint.

There was a policy in place for the management of residents' finances. Some residents managed their own finances independently and receipts were retained from shopping events and outings. Inspectors were informed that the management of residents' finances was now robust and on this inspection there were no complaints on financial matters, reported to inspectors. A money management protocol was seen to be in place for residents. Suitable oversight of financial transactions was in place for any resident assessed as having diminished capacity.

**Judgment:**

Substantially 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):**

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

**Findings:**

There was a record of all incidents and accidents maintained in the centre.

Notifications were submitted in a timely manner to the Authority, in line with Regulations.

**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):**

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

**Findings:**

Residents had access to general practitioner (GP) services and appropriate therapies, such as dentist, psychologist, dietician, occupational therapist (OT), psychiatrist and speech and language therapist (SALT). In some situations residents were enabled to independently visit their GP. There was evidence that residents had availed of allied health care services and specialist consultants. Residents could avail of the services of a local dentist. Residents had been assessed by the dietician and inspectors observed that care plans had been developed to support residents with diabetes and coeliac disease. The SALT had provided guidelines and training for safe swallowing for residents with dysphagia (swallowing difficulties) and the OT had documented recommendations for suitable chairs and assistive devices.

Regular multidisciplinary input was evident in a sample of residents' personal plans which were reviewed by inspectors. However, one resident who had been prescribed

pain relief did not have a care plan in place in relation to his pain. In addition, while there were two recognised pain assessment tools in his personal plan it was not clear to inspectors which tool was in use to evaluate his level of pain. There was no guidance for staff on the use of these assessment tools in his file and no indication if the tool had been used. In addition, not all staff had received training in the recognition and treatment of pain for non verbal residents or those with diminished capacity. This issue was addressed under Outcome 17: workforce. Furthermore, inspectors noted an absence of relevant pain management care plans in the files of a number of other residents who were prescribed pain relief. This issue was significant in view of a previous incident, where staff did not have training or evidence based tools, to identify whether a non verbal resident had pain or not.

Inspectors noted that residents had access to refreshments and snacks with a selection of fresh fruit and home baked bread. Residents, spoken with by inspectors, indicated that their individual likes and dislikes were taken into account when shopping and that they were encouraged to buy fruit and vegetables. Staff informed inspectors that they would accompany residents on shopping trips. One resident explained to inspectors how she used her iPad to order her shopping online.

There was a central kitchen in the main house and all residents were welcome to attend the dining room for meals. Inspectors noted that residents had a choice of three meals at lunchtime and there was a menu board available in the dining room. The meals looked appetising and modified diets were carefully prepared. Staff were seen to support residents with their meals as a number of residents required significant assistance at meal times. Most of the staff in the centre had received training in safe eating and swallowing as well as training in the management of swallowing difficulties. Relevant files relating to diets, fridge and food temperatures and cleaning schedules in the kitchen were maintained in good order in the centre and were made available to inspectors. The chef was knowledgeable about specific diets for residents with complex medical needs.

Inspectors observed that the ethos of the centre encouraged and enabled residents to make healthy living choices, in relation to exercise, weight control and dietary considerations. The dietician had been assessed for residents with weight control issues. Bariatric (extra large) wheelchairs, commodes and suitable wheelchair taxis were available for these residents. Staff with whom inspectors spoke were knowledgeable about residents' health and social care needs and were observed to provide care as outlined in the personal plans. Residents said that they were afforded opportunities socially, in line with their expressed preferences.

Night staff outlined to inspectors that there were a number of residents who required two and sometimes three members of staff to attend to their needs during the night. They stated that as there were five staff on duty until 22:00hrs, there were no issues at present around providing the care required. There was a staff nurse available in the centre every day and there was a nurse on call each night to provide advice and support if required. The person in charge was asked to maintain an audit and review of the night staffing levels and to ensure that the related risk assessments were updated, in line with the changing needs of residents. The person in charge stated that the organisations' decision to restrict the admission of respite residents, with complex needs, had a

positive impact on the availability of sufficient staff to provide the level of care required, to those residents' with high and maximum dependency, in the centre. A decision had also been made to cease all respite admissions from January 2016.

**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):**

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

**Findings:**

Inspectors found that improvements had been made to overall medicines management practices in the centre since the previous inspection in July 2015. However, the medication management outcome was found to be at the level of major non-compliance and unsuitable and inadequate practices were noted in relation to the administration, documentation and reviewing of medicines management practices.

Organisational policies and procedures in relation to medicines management was made available to inspectors which had been reviewed in August 2014. The policies and procedures were comprehensive and evidence based. The policies and procedures included the ordering, receipt, storage, administration, record keeping and disposal of medicines. The policies and procedures were made available to staff who demonstrated adequate knowledge of this document. An inspector observed administration practices and staff adopted a person-centred approach.

Medicines for residents were supplied by a community pharmacy. Records examined confirmed that the pharmacist was facilitated to meet his/her obligations as per guidance issued by the Pharmaceutical Society of Ireland. Staff with whom inspectors spoke confirmed there was timely access to medicines. Some residents were supported to collect their medicines from the pharmacy and staff reported that a pharmacist was available to meet with residents and their representatives.

Medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Medicines requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded daily. Robust measures were in place for the handling and storage of medicines with additional controls that were in accordance with current guidelines and legislation.



The medicines management policy outlined that each resident was encouraged to take responsibility for his/her own medication, in line with his/her wishes and preferences. An inspector saw that, for residents who took responsibility for their own medicines, a risk assessment and assessment of capacity was completed and reviewed regularly. However, the inspector saw that inadequate controls and oversight were in place to ensure compliance and adherence to residents' medicinal product therapy and treatment plan.

Compliance aids were used by staff to administer medicines. Complete resources were available to allow staff to confirm prescribed medicines in the compliance aid with identifiable drug information.

A sample of medication prescription and administration records was reviewed by an inspector. The administration records identified the medicines on the prescription sheet and allowed space to record comments on withholding or refusing medicines. However, the inspector noted that medicines (antibiotics) were not always administered as prescribed. A resident continued to receive antibiotics on the day of inspection where the course should have been completed a number of days previously. Handover documentation indicated that residents had received medicines even though there was no prescription available in the centre. This was confirmed by inspectors. A number of gaps were noted in the medication administration records where the record was left blank with no reason documented. In addition, as regards medication administration records, where a dose range of a liquid medicine was prescribed to be administered (e.g. 5-10ml), the actual dose administered was not recorded on the medication administration record.

A system was in place to identify, record, investigate and learn from medication related incidents. An inspector reviewed the reporting forms for such incidents since the previous inspection. A total of 39 medication-related incidents had been reported; 6 of which were 'near miss' events. The reporting forms indicated that similar incidents being repeated and there was evidence of medicines, including antibiotics, were omitted. However, as further outlined in Outcome 7: Health and Safety and risk management, some medication-related incidents were not reported and preventative actions were not always outlined or were inadequate.

Some residents required their medications to be crushed prior to administration and each individual prescription contained an authorisation by the prescriber to crush the medicine prescribed.

Staff with whom inspectors spoke outlined the manner in which medications which were out of date or dispensed to a resident but were no longer needed were stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. Inspectors noted that yellow 'sharps' bins were not used to dispose medicines as had been found on the previous inspection.

There was a system in place for the review and monitoring of safe medicines management practices. Regular audits were completed which examined a number of areas related to medicines management including storage, documentation, receipt and administration. Pertinent deficiencies were identified but it was not clear if preventative

actions and learning from reviews had been implemented; this is further outlined in Outcome 14: Governance and management.

Training records confirmed that training in medicines management had been facilitated for staff in 2014/2015. However, refresher training was not provided to staff as appropriate; this issue was covered in Outcome 17: Workforce.

**Judgment:**  
Non Compliant - Major

### **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:**

A recently updated statement of purpose was available and reviewed by inspectors. The statement of purpose described and reflected the day-to-day operation of the centre and the services and facilities provided for residents.

The person in charge confirmed that she kept the statement of purpose under review and provided inspectors with a copy of the most up-to-date version following the inspection. Inspectors noted that there was a copy of the statement of purpose available for residents in the centre.

**Judgment:**  
Compliant

### **Outcome 14: Governance and Management**

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

**Theme:**  
Leadership, Governance and Management

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

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

**Findings:**

There was a governance and management structure in place which was in accordance with the structure outlined in the statement of purpose. The person in charge informed inspectors that her post was full time and she was engaged in the governance, operational management and administration of all areas in the centre on a consistent basis. The person in charge said she had good support from the provider and the regional manager who participated in the management of the centre in her absence. There was a clearly defined management structure in the centre and the person in charge informed inspectors that a new senior clinical nurse manager (CNM2) would be appointed on 6 January 2015. The person in charge stated that her autonomy, authority and accountability had been affirmed by the organisation since the previous inspection and she ensured that all notifications were submitted in a timely manner to the Authority.

Staff informed inspectors that they were facilitated to discuss issues of safety and quality of care at handover meetings, which the person in charge and senior staff nurses facilitated. Staff appraisals were ongoing. There was a regular review of the quality and safety of care in the centre and audit of areas such as infection control, health and safety and medication management. Inspectors reviewed a health and safety audit, a fire safety audit, a medication management audit and an infection control audit carried out by the HSE infection control nurse in 2015. However, all actions recommended from these audits had not been implemented. For example, as previously outlined in Outcome 12: Medication management, there was a system in place for the reviewing and monitoring of safe medicines management practices. Pertinent deficiencies were identified but it was not clear if preventative actions and learning from reviews had been implemented. Audits identified deficits in staff knowledge relating to medicines management but an action plan to address this had not been completed. Sufficient supervision of staff involved in the administration of medications and refresher training for staff in medication management, where errors had occurred, was not in place. This training deficit was addressed under Outcome 17: Workforce.

**Judgment:**

Substantially 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):**

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

**Findings:**

There centre was resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose.

The facilities and services reflected the centre's statement of purpose. Inspectors found that there were sufficient resources in the centre to meet the current assessed 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:**

Satisfactory responses had been received in response to two immediate action plans issued to the provider on the previous inspection. These related to staffing levels, skill mix and training. Following findings on that inspection the person in charge stated that there was now a staff member on duty each night who was trained in medication management, including the administration of emergency epilepsy medication. Night staff, with whom inspectors spoke, confirmed that they had received this training. The person in charge said that a nurse would be rostered on duty if there was no suitably trained person on night duty. A programme of mandatory training had been rolled out and the majority of staff had attended this training. As addressed under Outcome 8: a small number of staff had yet to receive training in behaviours that challenge and de-escalation techniques. In addition, as previously outlined in Outcome 12: Medication management, refresher training was not provided to staff in medicines management following medication related incidents to prevent recurrence when similar errors were repeated. In addition, training in communication strategies, manual handling and in pain management had yet to be fully provided, as appropriate to the needs of residents in the centre and in relation to previous serious incidents.

A sample of staff files reviewed by inspectors generally complied with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013. However, not all the required documents were available for staff. For example, qualification

certification, photographic identification, references and job descriptions were not all available on the sample of staff files reviewed. Inspectors noted that staff supervision was more consistent in some areas than on the previous inspection. Staff had supervision and appraisal records available and disciplinary actions were followed through if required. Inspectors viewed the rota and the planned roster for the following week.

Inspectors found that staff had an understanding of their role and of the needs of residents. Staff demonstrated an awareness of the centre's policies and had access to a copy of the Regulations and the National Standards for the sector. Residents were familiar with the staff on duty on the day of inspection, which indicated continuity of care for residents. Extra staff had been put in place on a daily basis and this proved beneficial to residents in relation to access to external and internal activities. Staff confirmed with inspectors that the extra staff member enabled them to spend more quality time with residents. Residents spoke with inspectors about the improved availability of transport for shopping and activation.

**Judgment:**

Non Compliant - Moderate

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

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

**Findings:**

The directory of residents was reviewed by inspectors. It contained the elements required by Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Other records required under Schedule 3, had been maintained. For example, a restraint log was now maintained as required by the regulations.

All 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 were now in place in the centre. However, none of the policies reviewed by inspectors were found to be centre-specific as they were

organisation wide. However, where local protocols existed these were available in addition to the policies.

There was a Resident's Guide available in the centre. This guide was compliant with regulatory requirements. Inspectors viewed the insurance policy and noted that the centre was adequately insured against accidents or injury to residents, staff and visitors.

**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:***

Mary O'Mahony  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



#### Provider's response to inspection report<sup>1</sup>

|                            |   |
|----------------------------|---|
| <b>Centre name:</b>        | A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland |
| <b>Centre ID:</b>          | OSV-0003439   |
| <b>Date of Inspection:</b> | 04 December 2015  |
| <b>Date of response:</b>   | 30 December 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 04: Admissions and Contract for the Provision of Services

**Theme:** Effective Services

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

The registered provider had failed to ensure that the agreement for the provision of services included the support, care and welfare of the resident and where appropriate, the fees to be charged.

#### 1. Action Required:

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

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

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

The Person in Charge will amend the service agreements so as to ensure that they will now include the support, care and welfare of the residents and any fees which they are charged.

**Proposed Timescale:** 31/01/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

The external walls of the main house required repainting and the basement kitchenette required upgrading.

**2. Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

1. The external walls on the main building are limestone and require specialist treatment. The person in charge has sourced a contractor who is willing to review the work that will be needed in order to address the peeling walls and put forward an estimated costing.
2. The maintenance plan has been compiled and costings have been received. Work on the basement will commence on the 4th January 2016.

**Proposed Timescale:** 01/04/2016

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

The registered provider had not ensured that the risk management policy included the measures and actions in place to control the risks identified.

For example,

- there were gaps in evidence in the documentation for checking of designated fire door and required door and window closures at night
- there were gaps in the documentation for two hourly night time apartment checks



- there was no documentation available to indicate that the half hourly checks had been undertaken nightly on those residents who were unable to use a call bell.

### **3. Action Required:**

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

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

1. There is now a system in place a system for half hourly checks for residents who are unable to use a call bell. The person in charge / designate will carry out regular audits and any evidence of bad practice will be addressed, followed up and any learning will be shared amongst the staff teams.
2. The clinical management team are now responsible for auditing all documentation regarding health, safety and risk management. Any gaps in evidence in the documentation such as those listed above will be followed up with staff during a one to one review and will be documented.
3. A national learning log will be rolled out in early 2016 to ensure learning across all services in the area of risk management/clinical risk management. This will complement and be used alongside any local learning initiatives.

#### **Proposed Timescale:**

1. Completed
2. 31st January 2016
3. 31st March 2016

#### **Proposed Timescale:**

**Theme:** Effective Services

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

Preventative actions were not always outlined or completed.

The preventative actions implemented were not robust and did not mitigate the risk due to the pattern of repeated errors.

Risk assessment of the impact of repeated errors was not in place.

### **4. Action Required:**

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

1. A risk management plan will be developed for identifying, recording, investigating and learning from adverse incidents. This will include more frequent auditing of medication management and the management of medication errors.

2. A support and training plan is being developed in order to retrain and reassess any employee who makes repeated medication errors.
3. Going forward all employees who have responsibility for the administration of medication will have an annual performance appraisal which will include the reviewing of knowledge, skills and competencies in relation to managing and administering medicines.
4. A national learning log will be rolled out in early 2016 to ensure learning across all services in the area of risk management/clinical risk management. This will complement and be used alongside any local learning initiatives.

**Proposed Timescale:** 31/03/2016

#### **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

A small number of staff had yet to attend training in the management of behaviour that is challenging including de-escalation and intervention techniques.

##### **5. Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

1. Remaining Staff trained on the 15th December 2015, 2 staff unavailable on the 15th December 2015, these two staff will be trained in January 2016
2. All new staff hired since the 4th December 2015 will be trained in January 2016.

**Proposed Timescale:** 05/02/2016

#### **Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Residents who were prescribed pain relief did not have relevant and supporting documentation available in their personal plans.

##### **6. 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:**

All Residents who have been prescribed pain relief will have relevant and supporting documentation specifically detailed in their personal plans. This will include the use of pain scores which are most effective to the individual resident's needs.

**Proposed Timescale:** 31/01/2016

## **Outcome 12. Medication Management**

**Theme:** Health and Development

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

For residents who take responsibility for their own medicines, inadequate controls and oversight were in place to ensure compliance and adherence to residents' medicinal product therapy and treatment plan.

### **7. Action Required:**

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

1. An individual risk assessment has been completed for all residents who are self-medicating.
2. Each resident's care plan will be updated to include the level of support that they each require.
3. As part of the current review of all of the medication management policies and procedures within the organisation a system for monitoring whether the resident is still able to self-administer medicines will be included in their care plans which will also detail the ongoing supervision to ensure adherence with the treatment plan.

**Proposed Timescale:** 14/02/2016

**Theme:** Health and Development

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

Medicines were not always administered as prescribed to residents.

Medication-related incident forms indicated that medicines were sometimes omitted.

A number of gaps were noted in the medication administration records where the record was left blank with no reason documented.

In addition, the dose of a liquid medicine administered to a resident had not been recorded.

**8. Action Required:**

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

1. The nurse on duty will continue to carry out daily checks and the the person in charge / designate will carry out regular audits. Any evidence of bad practice will be addressed, followed up and any learning will be shared amongst the staff teams.
2. All employees who have responsibility for the administration of medication will have an annual performance appraisal which will include the reviewing of knowledge, skills and competencies in relation to managing and administering medicines.
3. A full review of medication management policies and procedures is currently underway within the organisation. A new Standard Operating Procedure for Medication Management will give clear explicit instructions on all areas of medication management.
4. A risk management plan will be developed for identifying, recording, investigating and learning from adverse incidents at both local and national level. This will include more frequent auditing of medication management as a whole as well as the management of medication errors.
5. A national learning log will be rolled out in early 2016 to ensure learning across all services in the area of risk management/clinical risk management. This will complement and be used alongside any local learning initiatives.
6. The training programme for medication management is currently under review and the new package will include a refresher training package. Both the standard training and the refresher training will include a new practical (Objective Structured Clinical Examination) exam in addition to the current written exams.
7. The audit plan for 2016 will include more frequent auditing of medication management and the management of medication errors.
8. A support and training plan is being developed in order to retrain and reassess any employee who makes repeated medication errors.

**Proposed Timescale:** 31/03/2016

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

It was not clear if preventative actions and learning from reviews of safe medicines management practices had been implemented.

**9. Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

1. The nurse on duty will continue to carry out daily checks and the the person in charge / designate will carry out regular audits. Any evidence of bad practice will be addressed, followed up and any learning will be shared amongst the staff teams.
2. All employees who have responsibility for the administration of medication will have an annual performance appraisal which will include the reviewing of knowledge, skills and competencies in relation to managing and administering medicines.
3. A risk management plan will be developed for identifying, recording, investigating and learning from adverse incidents at both local and national level. This will include more frequent auditing of medication management as a whole as well as the management of medication errors.
4. The organisational audit plan for 2016 will include more frequent auditing of medication management and the management of medication errors.
5. The training programme for medication management is currently under review and the new package will include a refresher training package. Both the standard training and the refresher training will include a new practical (Objective Structured Clinical Examination) exam in addition to the current written exams.
6. A support and training plan is being developed in order to retrain and reassess any employee who makes repeated medication errors.
7. A national learning log will be rolled out in early 2016 to ensure learning across all services in the area of risk management/clinical risk management. This will complement and be used alongside any local learning initiatives.

**Proposed Timescale:** 31/03/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The information and documents as specified in Schedule 2 had not been obtained for all staff.

**10. Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

All necessary information regarding Schedule 2 shall be obtained for all staff and present on their files going forward.

**Proposed Timescale:** 05/02/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement**

**in the following respect:**

Refresher training was not provided to relevant staff in medicines management following medication related incidents to prevent recurrence when similar errors were repeated.

Some staff required refresher training in manual handling.

In addition, training in pain management and in communication strategies had not been afforded to all staff as appropriate for the assessed needs of residents.

**11. 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:**

1. The training programme for medication management is currently under review and the new package will include a refresher training package. Both the standard training and the refresher training will include a new practical (Objective Structured Clinical Examination) exam in addition to the current written exams.
2. A support and training plan is being developed in order to retrain and reassess any employee who makes repeated medication errors.
3. Going forward all employees who have responsibility for the administration of medication will have an annual performance appraisal which will include the reviewing of knowledge, skills and competencies in relation to managing and administering medicines.
4. Refresher training in moving and handling will be provided to staff in January 2016
5. A small number of staff still require training in pain management, this training is currently being rolled out to staff and shall be completed in January 2016.
6. The speech and language therapist shall review the current needs of the residents who are non-verbal and ensure that all personal plans are updated to reflect the required supports that these residents require. Training will be provided where necessary to staff to ensure these supports are effective.

**Proposed Timescale:** 28/02/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

While all the policies required under Schedule 5 were available in the centre these were not centre specific.

**12. 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:**

All of the Policies which are required under Schedule 5 of the Health Act 2007 shall be made centre specific.

**Proposed Timescale:** 15/02/2016

**Theme:** Use of Information

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

Where a dose range of a liquid medicine was prescribed to be administered (e.g. 5-10ml), the actual dose administered was not recorded on the medication administration record.

**13. Action Required:**

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

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

1. A full review of medication management policies and procedures is currently underway within the organisation. A new Standard Operating Procedure for Medication Management will give clear explicit instructions on all areas of medication management.
2. A risk management plan will be developed for identifying, recording, investigating and learning from adverse incidents at both local and national level. This will include more frequent auditing of medication management as a whole as well as the management of medication errors.
3. The training programme for medication management is currently under review and the new package will include a refresher training package. Both the standard training and the refresher training will include a new practical (Objective Structured Clinical Examination) exam in addition to the current written exams.
4. The audit plan for 2016 will include more frequent auditing of medication management and the management of medication errors.
5. A national learning log will be rolled out in early 2016 to ensure learning across all services in the area of risk management/clinical risk management. This will complement and be used alongside any local learning initiatives.
6. A support and training plan is being developed in order to retrain and reassess any employee who makes repeated medication errors.
7. Going forward all employees who have responsibility for the administration of medication will have an annual performance appraisal which will include the reviewing of knowledge, skills and competencies in relation to managing and administering medicines.

**Proposed Timescale:** 31/03/2016