

**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-0003449
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Louisa Power
Support inspector(s):	Julie Hennessy;Shane Grogan
Type of inspection	Announced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	6

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:
24 November 2015 09:10	24 November 2015 17:00
25 November 2015 09:05	25 November 2015 14:40

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

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 inspection was an announced registration inspection, took place over two days and was the second inspection of the centre by the Authority. The centre comprised a large period two storey house and the courtyard buildings located in a rural location in Co. Limerick. As part of the inspection process, inspectors met with the provider nominee, person in charge, those participating in management, residents and staff members. Inspectors observed practices and reviewed documentation such as personal plans, medical records, policies and procedures. The documentation submitted by the provider as part of the application process was submitted in a timely manner and was examined prior to the inspection. Questionnaires completed by residents and their representatives were also reviewed; the feedback was positive and is referenced in the body of the report.

An inspection had taken in place in January 2015, following the Authority's receipt of unsolicited information, which focussed mainly on Outcome 11: Healthcare Needs. Inspectors noted that many of the actions from the previous inspection had been satisfactorily completed but an annual review of the quality and safety of care had not been completed. A formal on-call system had been put in place for nursing staff overnight and staff reported that it was working well.

Inspectors found evidence of good practice in some areas and residents told inspectors that they were well looked after. A good rapport between residents and staff was evident throughout the inspection and staff supported residents in a respectful and dignified manner. Residents were supported to develop and maintain personal relationships and links with the wider community. Positive relationships with families were encouraged.

Of the eighteen outcomes examined, three were found to be fully compliant with the regulations. Inspectors determined a finding of major non-compliance for four outcomes - Outcome 7: Health and safety and risk management, Outcome 9: Notification of incidents, Outcome 12: Medication management and Outcome 14: Governance and management. The non-compliances are discussed throughout the report and in the action plan at the end of the report

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Effective consultation mechanisms were in place. There were regular residents' meetings and minutes were kept of such meetings. Items included anything residents may or may not be happy with and there was evidence that issues raised were followed up on and addressed.

Residents had access to external advocates and availed of such services where required. An external advocate had visited the centre and spoken with residents.

There was CCTV (closed circuit television) in use and there was a policy in place in relation to CCTV. The person in charge confirmed that CCTV was not used in areas where there would be a reasonable expectation of privacy.

There were arrangements in place for the management of complaints including a complaint policy, a complaints procedure and a complaints log. The arrangements in place were reviewed and demonstrated an open culture where complaints could be raised.

Residents were supported to exercise their political and religious rights. Mass was celebrated on a weekly basis. Residents could chose whether to participate in religious services, according to their individual wishes.

Inspectors found that where a resident was unable to express his/her views in relation to restraint, it was not clear that a multidisciplinary assessment had been completed and a decision had been made in the best interests of the resident.

The policy in relation to the use of restraints required review to ensure that practices were in line with national policy or evidence-based practice. For example, the policy did not clearly protect the rights of an adult to give consent nor did it outline the decision-making process in the absence of capacity.

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:

At the previous inspection, it was found that the required steps had not been taken to support the diverse communication needs of all residents. Since that inspection, appropriate steps had been taken by the person in charge. There was a system in place to arrange for residents to have access to input from external professionals input to meet their communication needs, where necessary. Personal care plans outlined the different communication needs of residents. However, further improvement was required to ensure that all potential means of communication had been adequately explored for all residents. For example, interventions for a resident with specific communication needs were not consistently implemented and there was a risk that the resident would not be able to effectively communicate his/her needs at all times.

Residents were facilitated to access, where required, assistive technology to promote their full capabilities, such as computers and tablet technology.

Judgment:

Non Compliant - Moderate

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:

Positive relationships between residents and their family members were supported. Family members were invited to attend personal review meetings. Families were welcome to visit their loved ones in the centre. Residents were supported to go out with their relatives, to stay in their family home or to visit the graves of loved ones who had passed away.

Relationships with friends, colleagues, support groups or networks were also supported. For example, residents were supported to attend classes that they wished to attend in the community or to meet friends or work colleagues for a coffee or meal.

Activities based in the centre had been developed since the previous inspection. Activities included art therapy, music and increased opening hours for the swimming pool in the centre. A record of social activities was maintained in each resident's plan. The person in charge told inspectors that they were continuing to develop individual-based activities instead of group-based activities. Volunteers in the centre were involved in facilitating individual activities, based on a resident's wishes and interests.

Residents identified activities that they were interested in and other new opportunities were encouraged. Some residents attending a community centre for older adults where activities such as baking, bingo and a meal were available. Specialised day services were also provided to some residents with acquired brain injury external to the centre. Residents had recently been involved in discussing what they would like to do for Christmas.

Social outings were posted on a notice board and recent outings included a trip to a wildlife park. For some residents, overnight trips had also been organised in the previous few months.

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 policy on admissions, transfers and discharge of residents, which had been

reviewed in September 2015, was made available to inspectors. The policy outlined the transparent criteria for admission. Residents' admissions were seen to be in line with the statement of purpose. The admission practices did take into account of the need to protect residents from abuse by their peers. However, the policy did not outline same.

A sample of the written agreements with residents and their representatives which dealt with the support, care and welfare of the resident in the centre and included details of the services to be provided were viewed by inspectors. The contract did not clearly outline what the fee covers and details of additional charges.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Each resident had an assessment of health, personal and social care and support needs and a written personal plan. Since the previous inspection, the personal plan had been developed to assess social needs and set social goals. Overall, the supports required to achieve goals and how goals contributed to residents' quality of life were outlined. However, some further improvement was required to the setting of goals, particularly long-term goals such as living independently or moving to a community-based house.

Improvement was required in relation to the tracking of goals and the review of the personal plan. The review process was not sufficiently clear, for example, it did not clearly assess the effectiveness of the plan and document the rationale for any such proposed changes. While residents had access to a multidisciplinary team on a quarterly basis, it was not clear how the multidisciplinary team contributed to the review of the personal plan, as required by the regulations.

It was demonstrated that the personal plan had been developed in consultation with residents and personal plans were signed by residents. Where applicable, family members were involved in the development of the personal plan. However, the personal plan was not in an accessible format for all residents.

The centre was a congregated setting and the person in charge told inspectors that a transition plan was being developed in relation to de-congregation. The person in charge identified a small number of residents who had expressed an interest in living in a community-based setting. A transition plan was not available for review in the centre during the inspection.

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 centre comprised a large period two-storey period house and the courtyard buildings. It was located approximately 5km from Newcastle West. Attractive, mature and well maintained grounds surrounded the centre. There was adequate private and communal space for residents. Each resident had their own bedroom or apartment which was personalised with the resident's choice of soft furnishings, photographs of family and friends and personal memorabilia. Ample storage space was provided for residents' personal use.

Accommodation for residents in the main house was provided on the ground floor only. Offices and staff facilities were located on the first floor. There were ten single en-suite bedrooms, eight studio apartments and four one-bedroom apartments on the ground floor. The apartments provided en-suite sanitary facilities and an area for preparing food. Communal areas in the main house included a sitting room, a pleasant oratory and a dining room. A designated smoking room was provided for residents. Accessible toilet facilities were located in close proximity to the communal areas. There was an adequate laundry area and staff reported that residents were supported to launder their own clothes if they so wished. Inspectors saw that residents availed of the hydrotherapy pool and a physiotherapy room.

The courtyard buildings were renovated in 2006 and comprised five one-bedroom apartments which each opened onto an attractive communal patio area. A large communal space which included a dining area was located beside the kitchen facilities. A bedroom was provided for sleepover staff.

The sitting room in the main house lacked a homely and comfortable feel. The décor and furniture were not particularly comfortable and inviting. Inspectors observed that residents did not regularly use the sitting room in the main house preferring to frequent the dining area or designated smoking area. Activities were observed to be facilitated in the dining area of the main house. The dining room was not suitable for this purpose as it had an open serving area from the kitchen and was furnished with dining tables.

There was a separate kitchen area in both the main house and the courtyard with suitable and sufficient cooking facilities and kitchen facilities. However, these kitchen facilities were not suitable for residents to prepare their own meals. This is further outlined in Outcome 11: Healthcare Needs.

The centre was clean, suitably decorated and reasonably well maintained. However, inspectors noted some areas of damaged and peeling paintwork in apartments/bedrooms in the main house. There was suitable heating, lighting and ventilation. There were suitable and sufficient furnishings, fixtures and fittings. There were suitable arrangements for the safe disposal of clinical and general waste.

Inspectors viewed a service contract for beds in the centre. Where bedrails were fitted to the beds, there was no arrangement in place either through the service contract and/or some other means to demonstrate that bedrails were checked, maintained and repaired or replaced where necessary.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

There were policies and procedures in place that were up to date, including a risk management policy, a safety statement, an emergency plan, a fire safety policy and infection control guidelines.

The centre maintained a risk register, which included a range of risk assessments. However, improvements were required in relation to risk management as not all risks had been adequately assessed. For example, there was no risk assessment relating to the risk of fire in the laundry room and the use of the drier at night within that room. The infection control risk assessment required improvement as it did not consider the controls required in the laundry room or sluice room. The risk assessment for bedrails identified generic risks (such as the risk of entrapment or entanglement) but did not

consider all of the potential risks associated with the use of bedrails for an individual resident (such as the risk of climbing over the bedrail or the integrity of the bedrail itself). In addition, the risk rating within risk assessments did not always reflect the actual risk to residents, e.g. in relation to the risk of choking.

Fire drills were being completed on a regular basis and a night-time practice fire drill had recently taken place. A detailed record of each fire drill was maintained. There were fire doors throughout the centre. Servicing records demonstrated that the servicing of fire equipment, the fire alarm system and emergency lighting was up to date.

A quality and safety audit had been completed in September 2015 with input from the organisation's health and safety officer. Areas for development had been identified and it was evidenced that action had been taken to address such areas. For example, seals on fire doors had been fitted and improvements had been made to the recording of fire drills. An outstanding action related to the need for a fire suppression system in the kitchen and this was being progressed by the person in charge. In the interim, the person in charge explained that steps had been taken to control the risk (i.e. the deep fat fryer was not being used).

However, significant improvement was required in relation to certain aspects of fire safety management. A review of both day-time and night-time fire drill records indicated that the arrangements in place for evacuating all persons in the centre were not adequate and were not timely. Records from the recent night-time drill on 19.11.2015 indicated that it took 26 minutes to evacuate the centre. Records from recent day-time drills on 16.11.2015, 17.9.2015, 2.9.2015 and 18.5.2015 indicated that it took between eight and nine minutes to evacuate the centre.

The person in charge responded promptly to this failing by organising a further drill and agreeing to seek input from suitably qualified persons in relation to the personal evacuation plans and ensuring the centre could be evacuated in a more timely manner.

Each resident had a personal emergency evacuation plan (PEEP) outlining any support a resident may require in the event of an evacuation. An inspector reviewed a sample of PEEPs and found that they required improvement. The information within the PEEPs was not sufficiently clear to provide guidance to staff.

The procedures to be followed in the event of a fire were not prominently displayed or readily available in the centre. In one part of the centre, neither the fire procedures nor evacuation plan was displayed or available. In another part of the centre, while the fire procedures were displayed, the evacuation plan outlining how to support each resident to evacuate in the event of a fire was not. Finally, training records indicated that 14 staff required fire safety training.

The fact that the arrangements in place for evacuating all persons in the centre were not adequate, coupled with the additional failings in relation to the personal evacuation plans, fire safety training and the procedures to be followed in the event of a fire meant that fire safety failings were at the level of major non-compliance.

Incidents were being recorded and reported and a log of incidents was maintained.

Insurance certificates, tax, servicing records (where applicable) and certificates of registration and licensing were viewed for all vehicles.

Since the previous inspection, nursing staff had received training in relation to the delivery of hand hygiene training. While training in hand hygiene had been delivered to most staff in-house, some staff still required this training. Inspectors observed that the centre appeared superficially clean. There were cleaning records in place that were maintained. An inspector spoke with household staff who confirmed what relevant training they had received and were clear in relation to the cleaning procedures in place.

Judgment:
Non Compliant - Major

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:

There was a policy and procedures in place for the prevention, detection and response to abuse. Staff were trained in relation to such policies and procedures and were able to articulate what to do in the event of a suspicion or allegation of abuse. Not all staff had received training in relation to the management of behaviours that may challenge, as required by the regulations.

Where required, residents had a mental health care plan and behaviour support plan. An inspector reviewed a sample of behaviour support plans and found that they demonstrated a positive approach to behaviour that may challenge. The behaviour support plan included possible causes, triggers, warning signs, proactive strategies, reactive strategies and debriefing following an incident. The person in charge and other staff articulated how they support residents in a positive way to manage their own behaviours. Behaviour supports were reviewed by the multidisciplinary team. A psychology assessment was outstanding for one resident but inspectors found that the person in charge had taken adequate steps to progress this assessment.

There was a policy in relation to the use of restraints. Aspects of the policy required review to ensure that practices were in line with national policy or evidence-based practice and this is addressed under Outcome 18: Records and documentation.

A log of physical restraints in use was maintained in the centre. Where applicable, restraints in place for postural or safety reasons had been recommended by the occupational therapist (OT).

An inspector reviewed a sample of risk assessments for bedrails and lap belts. However, it was not evidenced that the controls outlined in the risk assessments were being implemented. For example, one control stated that bedrails were to be checked every two hours but there was no record of such checks. Another control documented by the OT related to the need to release a lap belt at regular intervals so that the maximum continuous time the lap belt would be in place is four hours but there was no record being maintained to demonstrate that the recommendations of the OT were being followed.

Judgment:

Non Compliant - Moderate

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 centre was maintained.

A written report at the end of each quarter in relation to incidents occurring in the centre was submitted as required.

Inspectors found that while a complaint relating to an allegation of verbal abuse had been managed according to the organisation's own internal processes, it had not been notified to the Authority as required under the regulations.

Judgment:

Non Compliant - Major

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:

There was a policy on access to education, training and development. The policy did not meet the requirements of the regulations and this is addressed under Outcome 18.

Residents availed of a day service where applicable. Links had been developed to support residents to participate in work placement programmes or training courses. The person in charge identified approximately five residents who could avail of supported employment. The assessment process in place to establish and realise each resident's educational/training/employment goals was not clear.

There was a policy on access to education, training and development. The policy did not consider all of the relevant regulations as it did not outline the arrangements in place to support residents to access opportunities for education, training and employment or to support residents in transition between services.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Timely access to healthcare services and appropriate treatment and therapies was provided. A medical practitioner of their choice was available to each resident and an "out of hours" service was available if required. Inspectors saw that residents were reviewed by the medical practitioner regularly and medical advice and consultation was seen to be sought in a timely fashion. There was clear evidence that their treatment was recommended and agreed by residents, this treatment was facilitated. Residents' right to refuse medical treatment was respected.

Where referrals were made to specialist services or consultants, inspectors saw that staff supported residents to attend appointments. In line with their needs, residents had ongoing access to allied healthcare professionals including physiotherapy, dental, psychiatry, psychology, palliative care, speech and language, dietetics, chiropody and occupational therapy. The recommendations of allied healthcare professionals were

included in care plans and were seen to be implemented in practice.

A documented 'best possible health' assessment was completed for all residents and informed the development of care plans for residents in consultation with residents and their representatives. The assessments and care plans were reviewed annually, or in line with a resident's changing needs. The assessment included communication, personal care, skin care, elimination, eating and drinking, respiratory, medicines management, mobility, mental health and lifestyle. Inspectors saw that evidence based tools were in use for the ongoing monitoring of weight loss, continence and pressure area management. An assessment tool was in place for measuring a resident's risk of falling but it was not clear whether the tool was evidence based. Inspectors saw that where a resident had difficulty sleeping and had been prescribed sleeping tablets, there was no sleep chart in place to monitor the effectiveness of the medicine or to identify underlying cause.

Inspectors noted that some of the residents were prescribed pain relief on a regular and an 'as required' (PRN) basis. Care plans were in place to guide staff in relation to the individualised management of pain and an evidence based tool was available to assess pain using a pain score. However, inspectors saw that care plans in relation to pain were not always followed. For example, a resident's care plan outlined that if PRN pain relief was administered, the pain score was to be recorded. An inspector noted that PRN pain relief was administered to a resident on three consecutive days without a pain score being recorded in the resident's record.

Care plans were developed to guide staff in the management of epilepsy which outlined the type of epilepsy, medicines prescribed, arrangements for specialist management and procedure to be followed in the event of a seizure. However, some of the care plans were generic in nature, not individualised and did not take into account that rescue medicine had been prescribed for a resident. The care plan was not always followed as the seizure record did not record the level consciousness, continence and resident's condition following the seizure as outlined in the care plan.

Robust procedures were in place and implemented in order to identify and manage residents in the event of clinical deterioration in a timely and appropriate manner. A comprehensive early warning and observation chart which included pallor, temperature, respiration rate, consciousness level and urine output guided non-nursing staff when to increase the frequency of observations and to alert the nurse on duty. Inspectors saw that this was used appropriately and staff articulated an understanding of the document.

Residents were encouraged and enabled to make healthy living choices in relation to exercise, weight control and healthy eating. Residents' weights were monitored on a monthly basis (or more frequently if required) and the Malnutrition Universal Screening Tool (MUST) was also utilised in practice. The inspector saw that residents looked well, weights were stable, residents were not experiencing weight loss and nursing staff understood the relevance of weight loss when computing the MUST. Staff with whom inspectors spoke demonstrated adequate knowledge of residents' needs in relation to diet and fluids of modified consistency and this was evidenced in practice. The policy on food and nutrition required review and this is further outlined in Outcome 18: Records and documentation.

The food served was sufficient in quantity, freshly prepared, nutritious and wholesome and was of a good standard. There was evidence that choice was available to residents for breakfast, lunch and evening tea with respect to menu options and dining location. The menu for the day was displayed on a whiteboard in the dining area of the main house and the courtyard. Inspectors observed that meal times were unhurried, positive and social events. Assistance was provided in a dignified and appropriate manner. All staff had received dysphagia training. Snacks and refreshments were observed to be available at all times. However, as outlined in Outcome 6: Safe and suitable premises, the kitchen facilities were not suitable for residents to prepare their own meals and the kitchenette area in apartments was limited.

Inspectors saw that care and support at end of life or times of illness was provided in a way that met the resident's individual physical, emotional, social and spiritual needs. The resident's dignity, autonomy and rights were respected. A process was in place to sensitively capture and document each resident's wishes and these were seen to be respected. However, this was not consistent and the wishes of some residents in relation to care and support at times of illness or end of life were not elicited or documented.

Residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. Health information specific to residents' needs was available in an easy read format.

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):

No actions were required from the previous inspection.

Findings:

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. The policy confirmed that residents were supported to manage their own medicines and outlined the assessments in place to support this. Staff with whom inspectors spoke confirmed that no resident was managing their own medicines at the time of the inspection.

A medication related incident was identified on the second day of the inspection by an

inspector whereby a resident was receiving a medicine at 50% of the dose prescribed. This was immediately brought to the attention of nursing staff on duty and an investigation in relation to the incident was commenced.

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 and that a pharmacist was available to meet with residents and their representatives. Medicines were checked on receipt and a documented record was maintained.

Medicines were stored securely and medicines requiring refrigeration were stored appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded daily. Storage of medicines with additional controls was safe and in accordance with current guidelines and legislation. The balance was checked at the handover of shift at 08:00 and 22:00. However, the balance was not checked at the handover of the afternoon shift to maintain a robust chain of custody.

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. Gaps were noted in medication administration records and this is further outlined in Outcome 18: Records and documentation.

Where medications were to be administered in a modified form such as crushing, this was not individually prescribed by the medical practitioner on the prescription chart. The maximum dose was not prescribed for all 'as required' (PRN) medicines to ensure that the maximum daily dose was not exceeded. These medicines included steroid creams where the dispensing label included a warning not to exceed the stated dose.

A system was in place to identify, record, investigate and learn from medication related incidents. There was evidence that learning from medication related incidents was implemented.

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.

There was a system in place for the reviewing 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 for staff in relation to medicines management had been completed in 2014/2015.

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):

No actions were required from the previous inspection.

Findings:

The statement of purpose consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for residents. Inspectors found that the statement of purpose was clearly implemented in practice. The statement of purpose was made available to residents and their representatives. The statement of purpose had been last reviewed in May 2015.

The statement of purpose contained some of the information required by Schedule 1 of the regulations. However, the following were not clearly outlined:

- a description (either in narrative form or a floor plan) of all rooms in the designated centre including their size and function
- details of all specific therapeutic interventions in the designated centre and arrangements for their supervision
- arrangements for residents to access education, training and employment
- arrangements for contact between residents and their relatives, friends, representatives and local community
- fire precautions and associated emergency procedures.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

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

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

Findings:

There was evidence of a defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. Staff with whom inspectors spoke were clear about the management structure and the reporting mechanisms.

The person in charge had been appointed in October 2014. The person in charge was employed full time by the organisation. The person in charge was suitably qualified and had completed a post graduate certificate in management in 2010. The employment history of the person in charge indicated that he had supported people with a disability since 2006. The person in charge reported to the regional manager and there was evidence of regular formal supervision and appraisal.

A written report of an unannounced visit by people nominated by the registered provider was completed in September 2015. The provider nominee confirmed that an annual review of the quality and safety of care and support in the designated centre had not been completed.

There was evidence of ongoing review of the quality and safety of care in the centre. A recent internal audit had been completed in October 2015 and examined a number of pertinent areas including consultation, safeguarding, social care and premises. The internal audit identified areas for improvement and audit recommendations. Improvements were brought about as a result of learning from the internal audit. However, as previously outlined in Outcome 12: Medication management, pertinent deficiencies were identified in the medicines management audit but it was not clear if preventative actions and learning from reviews had been implemented.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

There had been no periods where the person in charge was absent from the centre for 28 days or more since the last inspection and there had been no change to the person in charge. The provider nominee was aware of the obligation to inform the Chief Inspector if there is any proposed absence of the person in charge and the arrangements to cover for the absence.

There were adequate arrangements in place for the management of the centre when the person in charge is absent. The clinical nurse manager and the service co-ordinator were identified to deputise for the person in charge in his absence. An inspector spoke with the clinical nurse manager and service co-ordinator who both demonstrated a good understanding of the responsibilities when deputising for the person in charge. Inspectors were satisfied that suitable arrangements were in place for the management of the designated 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:

Inspectors found that the centre was adequately resourced to ensure the effective safe and effective delivery of care and support in accordance with the statement of purpose. Sufficient resources were available to provide support in achieving the planned goals and aspirations. Inspectors observed that there was sufficient transparency in the planning and deployment of resources in the centre. The facilities and services available in the designated centre reflected the statement of purpose.

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

Theme:

Responsive Workforce

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

Findings:

There was a planned and actual staff roster in place which showed the staff on duty during the day and night. Based on observations, a review of the roster and these inspection findings, inspectors was satisfied that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs of the residents. A regular team supported residents and this provided continuity of care and support. Nursing staff were not on duty from 22:00 to 08:00. In response to the findings in the previous inspection, a formal on-call system for regular nursing staff was in place to support non-nursing staff overnight. The log of calls to the on-call system was reviewed by an inspector who noted that appropriate calls were made and a timely response was provided. Staff with whom inspectors spoke were familiar with the on-call system and reported that it was operating satisfactorily.

A sample of staff files was reviewed and found to contain all the required elements. There was evidence of effective recruitment and induction procedures; in line with the policy reviewed in December 2013. Documentary evidence of up-to-date registration with the relevant professional body was provided where appropriate.

Robust procedures were in place for formal supervision of staff. The supervision was of good quality and actions improved practice and accountability.

The person in charge outlined that rolling team meetings took place with nursing staff, support staff and the senior team on a monthly basis. Minutes made available to inspectors outlined that pertinent issues were discussed with each group. Inspectors saw that copies of both the regulations and the standards had been made available to staff and staff spoken with demonstrated adequate knowledge of these documents.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies. The programme reflected the needs of residents. However, as outlined in the relevant outcomes, gaps were noted in mandatory infection prevention and control, fire and challenging behaviour training. There were also gaps in training relating to epilepsy and catheter care for non-nursing staff who could potentially work at night without on-site nursing support.

Volunteers received supervision and vetting appropriate to their role and level of involvement in the centre.

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):

No actions were required from the previous inspection.

Findings:

The records listed in Schedules 2, 3 and 4 of the regulations were maintained in the centre. All of the key policies as listed in Schedule 5 of the regulations were in place. These policies were made available to staff and discussed at staff meetings. Staff with whom inspectors spoke demonstrated a clear understanding of these policies. However, as outlined in the previous relevant outcomes, a number of organisational policies required review. The policy in relation to the use of restraints required review to ensure that practices were in line with national policy or evidence-based practice. For example, the policy did not clearly protect the rights of an adult to give consent nor did it outline the decision-making process in the absence of capacity. There was a policy on access to education, training and development. The policy did not consider all of the relevant regulations as it did not outline the arrangements in place to support residents to access opportunities for education, training and employment or to support residents in transition between services. The policy on food and nutrition did not outline the monitoring and documentation of nutritional intake.

An inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the regulations.

Residents' records as required under Schedule 3 of the regulations were maintained. However, incomplete medication administration records were noted. There were gaps noted in some medication administration records where the record was left blank with no reason documented. Where a dose range was prescribed to be administered (e.g. one or two tablets), the actual dose administered was not recorded on the medication administration record. The time of administration was not always recorded.

Records listed in Schedule 4 to be kept in a designated centre were all made available to inspectors.

Records were kept securely, were easily accessible and were kept for the required period of time. Residents' records were stored securely.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the regulations.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Louisa Power
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-0003449
Date of Inspection:	24 November 2015
Date of response:	13 January 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Where a resident was unable to express his/her views in relation to restraint, it was not clear that a multi-disciplinary assessment had been completed and a decision had been made in the best interests of the resident.

1. Action Required:

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

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

The Occupational Therapist to complete an assessment on consent in relation to restraint for the specific resident and the outcome to be discussed at that residents MTD meeting. Also where applicable a Speech & Language Therapist will work with the resident to ensure that each resident can exercise their civil, political & legal rights.

Proposed Timescale: 31/01/2016

Theme: Individualised Supports and Care

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

The restraint policy did not clearly protect the rights of an adult to give consent nor did it outline the decision-making process in the absence of capacity.

2. Action Required:

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

The Cheshire Ireland Restraints Policy to be reviewed to include information around protecting the rights of an adult to give consent and outline the decision-making process in the absence of capacity.

Proposed Timescale: 31/01/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Improvement was required to ensure that all potential means of communication had been adequately explored for all residents.

3. Action Required:

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

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

An assessment of need to be completed on each resident around communication with the support of the Occupational Therapist. Recommendations from the assessment of

need to be included in each resident's personal plan and followed up on by staff.

Proposed Timescale: 28/02/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The admissions policy did not outline the need to protect residents from abuse by their peers.

4. Action Required:

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

Also where applicable a Speech & Language Therapist will work with the resident to take account of the need to protect residents from abuse by their peers.

The Admissions policy to be reviewed and include the need to protect residents from abuse by their peers to be included.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

The agreement did not clearly outline the fees to be charged and the details of additional charges.

5. Action Required:

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

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

The Agreements have now been reviewed and changed to reflect the fees to be charged and the details of additional charges

Proposed Timescale: 31/01/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

The person in charge identified a small number of residents who had expressed an interest in living in a community-based setting. A transition plan was not available for review in the centre during the inspection.

6. Action Required:

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

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

The transition plan for the Limerick Cheshire Services to be approved by Cheshire Ireland Head of Operations. Information for each resident considering a transition to be included in their personal plan. This will also include long term and short term goals.

Proposed Timescale: 28/02/2016

Theme: Effective Services

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

Further improvement was required to the setting of goals, particularly long-term goals such as living independently or moving to a community-based house.

7. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

Personal plans to be reviewed to reflect the wishes of each individual around goal setting. Long term and short term goals to be outlined clearly at the front of each individual's personal plan

Proposed Timescale: 28/02/2016

Theme: Effective Services

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

It was not demonstrated how the review of the personal plan was multi-disciplinary.

8. 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:

The Multi-Disciplinary team will be present for the review of each individuals goals and this will be included in the clinical notes as well as the minutes of the meeting. Each relevant multi-disciplinary team member will be as to input where relevant to support the individual to attain their goals. Where an individual needs an accessible format this will be catered for.

Proposed Timescale: 28/02/2016

Theme: Effective Services

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

Improvement was required to assess the effectiveness of the personal plan and in relation to the tracking of goals.

9. Action Required:

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

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

Personal plans to be reviewed to reflect the wishes of each individual around goal setting. Long term and short term goals to be outlined clearly at the front of each individuals personal plan and reviewed formally every 3months or after a change in circumstance, the personal plan will be update as required after each review.

Proposed Timescale: 28/02/2016

Theme: Effective Services

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

Improvement was required in relation to the review of the personal plan.

10. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Personal plans to be reviewed to reflect the wishes of each individual around goal setting. Long term and short term goals to be outlined clearly at the front of each individuals personal plan and reviewed formally every 3months or after a change of

circumstance, the personal plan will be update as required after each review with an person responsible for following up on the actions in an agreed timescale.

Proposed Timescale: 28/02/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Some parts of the centre lacked a homely feel and, as a result, residents did not use some of the social and recreational facilities.

11. 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:

The residents of the service will be consulted to seek input into the decoration of the sitting room and how they would like to use this room. Management to support the service to make the room feel homely as a convenient location for residents to entertain family or guests.

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

There was some evidence of peeling and damaged paintwork.

12. 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:

The service has a maintenance plan for 2016. The 2015 maintenance plan was submitted to HIQA in December 2015. Works in the house will be remedied in a consistent and timely manner. The maintenance log will continue to be maintained on a daily basis.

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

Where bedrails were fitted to the beds, there was no arrangement in place either through the service contract and/or some other means to demonstrate that bedrails were checked on a regular basis, maintained and repaired or replaced where necessary.

13. 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:

There is a daily check list for care support staff to check the bedrails on a daily basis. There is now a formal procedure around the reporting of faults in the bed rails in the maintenance book. Any repairs or replacements are done in a timely manner by the maintenance team or service contractor where needed.

Proposed Timescale: 31/01/2016

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:

Improvements were required in relation to risk management as not all risks had been adequately assessed.

14. Action Required:

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

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

Risk Assessment on infection control in the laundry room is now completed.

The practice of sluicing is now discontinued and replaced with procedures around prewashing.

Risk assessment on Fire in the laundry room to be completed by Jason O'Regan Cheshire Ireland Health and Safety Officer.

An individual risk rating that was outlined as being incorrect is now corrected.

Risk assessment around bed rails to be reviewed to include a situation where a resident may attempt to climb over the rails.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

Fire drill records did not demonstrate that the arrangements in place for evacuating all persons and bringing them to a safe location were adequate. In addition, the personal emergency evacuation plans were not sufficiently clear to guide staff.

15. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

All PEEPS have been reviewed to give clear concise guidance to staff around day and night time evacuation.

Proposed Timescale: 16/12/2015

Theme: Effective Services

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

The procedures to be followed in the event of a fire were not prominently displayed or readily available in the centre. In one part of the centre, neither the fire procedures nor evacuation plan was displayed or available. In another part of the centre, while the fire procedures were displayed, the evacuation plan was not.

16. Action Required:

Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

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

Further individual risk assessment around a certain resident's PEEP completed by Jason O' Regan Cheshire Ireland Health and Safety Officer on 05-01-2016. Detailed action plan involving having an additional fire door being put in place to facilitate staff evacuating the resident on his bed should same be required in place Jan 11th, 2016.

New fire door to be in place by Feb 28th, 2016

Fire evacuation plan for both the Main House & Courtyard drafted by Jason O 'Regan Cheshire Ireland Health and Safety Officer, completed Jan 5th, 2016

Fire procedures and evacuation plan to be displayed prominently in the both sections of the building Jan 11th.

Proposed Timescale: 28/02/2016

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:

Not all staff had received training in relation to the management of behaviours that may challenge, as required by the Regulations.

17. 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:

Training in the management of behaviour that is challenging to be arranged for staff who are outstanding in the training. Training to be rolled out Feb 23rd to 25th, 2016.

Proposed Timescale: 31/01/2016

Theme: Safe Services

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

It was not demonstrated that the use of restrictive procedures was carefully monitored. As discussed in the findings, improvement was required in relation to the implementation of necessary controls for the use of bedrails and lap belts.

18. 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:

There is now check lists in place as required for each resident. These are filled in on a daily basis for each resident as required.

Proposed Timescale: 16/12/2015

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:

Inspectors found that while a complaint relating to an allegation of verbal abuse had been managed according to the organisation's own internal processes, it had not been notified to the Authority as required under the regulations.

19. 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:

A retrospective notification of the NF06 was sent to HIQA on the 26th of November 2015.

The Service Manager met & worked with the two PPIMs on the 04-12-2015 around the correct protocol for HIQA notifications, including the different types of notifications & deadlines surrounding same.

The correct protocol was discussed at length at the Senior Team Meeting 10-12-2015 involving all heads of departments.

Service Manager & one of the PPIM attended a one day HIQA training seminar 16-12-2015 which also detailed the correct protocol around HIQA notifications.

Proposed Timescale: 16/12/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

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

The assessment process in place to establish and realise each resident's educational/training/employment goals was not clear.

20. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

Each resident to be supported to ascertain their wishes around education/training and employment. Wishes will then be linked to the personal plan goal setting and followed up on in the personal plan review process.

Proposed Timescale: 28/02/2016

Theme: Health and Development

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

The policy on access to education, training and development did not outline the arrangements in place to ensure that residents were supported to access opportunities for education, training and employment.

21. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to

access opportunities for education, training and employment.

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

The Policy on access the education, training and development to be reviewed to outline arrangements to ensure residents were supported to access opportunities for education, training and employment.

Proposed Timescale: 31/01/2016

Theme: Health and Development

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

The policy on access to education, training and development did not outline the arrangements in place to ensure that where residents are in transition between services, continuity of education, training and employment is maintained.

22. Action Required:

Under Regulation 13 (4) (b) you are required to: Ensure that where residents are in transition between services, continuity of education, training and employment is maintained.

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

The policy on access to education, training and development to be reviewed to outline the arrangements in place to ensure that where residents are in transition between services, continuity of education, training and employment is maintained.

Proposed Timescale: 31/01/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Some care plans were generic and not individualised.

Care plans were not always followed.

It was not clear that assessment tools in use were evidence based.

Sleep charts were not used, where appropriate, to monitor the effectiveness of prescribed medicines or to identify underlying cause.

23. 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 care plans to be reviewed and made individual. Care plans to be updated. Staff are too fully comply with and ensure all care is provided as per the care plan. This will be audited by PIC or designate on a monthly basis. Assessment tools around pain are being used by care staff when given pain medication and reviewed again 30mins later. Sleep charts to be put in place for any individual on medication to support good sleeping patterns. The sleep charts and pain medication charts will be audited the PIC or designate on at least a monthly basis.

Proposed Timescale: 31/01/2016

Theme: Health and Development

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

The wishes of some residents in relation to care and support at times of illness or end of life were not elicited or documented.

24. Action Required:

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

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

Community Coordinator will link with the individual in question and support them to articulate and record their wishes around acute care needs.

Proposed Timescale: 31/01/2016

Theme: Health and Development

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

Kitchen facilities were not suitable for residents to prepare meals and snacks.

25. Action Required:

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

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

The residents will be support to articulate if they wish to prepare meals in their own kitchens. Supports will be put in place for each resident based on their wishes. Residents will also be offered cooking classes in the community and supported to attend if they wish.

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:

The balance of medicines with additional controls was not checked at the handover of the afternoon shift to maintain a robust chain of custody.

26. Action Required:

Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

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

The controlled medications are now checked and signed for on each handover. This will be reviewed by the PIC or Designate on a monthly basis.

Proposed Timescale: 26/11/2015

Theme: Health and Development

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

A medication related incident was identified on the second day of the inspection by an inspector whereby a resident was receiving a medicine at 50% of the dose prescribed.

Where medications were to be administered in a modified form such as crushing, this was not individually prescribed by the medical practitioner on the prescription chart.

The maximum dose was not prescribed for all 'as required' (PRN) medicines to ensure that the maximum daily dose was not exceeded.

27. 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:

Medications are received from the pharmacy ten days in advance of when they are required. This allows for medications to be checked. Also, MARS and Kardex are cross referenced during this period.

All Kardexes have been amended, reviewed and signed off on by GPs where medications require crushing- these are individually signed off by the GP.

All medication related AERs are to be read and evaluated at all Nurses meetings to share learnings & prevent future AERs

All Kardexes checked and amended where needed to reflect PRN medication max dose in 24 hour

Proposed Timescale: 16/12/2015

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:

The statement of purpose did not include or clearly outline:

- a description (either in narrative form or a floor plan) of all rooms in the designated centre including their size and function
- details of all specific therapeutic interventions in the designated centre and arrangements for their supervision
- arrangements for residents to access education, training and employment
- arrangements for contact between residents and their relatives, friends, representatives and local community
- fire precautions and associated emergency procedures.

28. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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:

The actions outlined in the above are now complete and the statement of purpose was sent to HIQA in December 2015

Proposed Timescale: 16/12/2015

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:

An annual review of the quality and safety of the care and support in the centre had not been completed.

It was not clear if preventative actions and learning from reviews/audits had been implemented

29. 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:

An annual review of the quality and safety of the care and support in the centre to be completed by the service provider

Proposed Timescale: 20/02/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Gaps were noted in training in relation to epilepsy and catheter care for non-nursing staff

30. Action Required:

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

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

All staff now trained in epilepsy. Training is scheduled in January/February 2016 for all remaining staff to complete around catheter care.

Proposed Timescale: 15/02/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

The following policies required review:

- policy in relation to the use of restraints to ensure that practices were in line with national policy or evidence-based practice
- policy on access to education, training and development to consider all of the relevant Regulations and to include arrangements in place to support residents to access opportunities for education, training and employment or to support residents in transition between services
- policy on food and nutrition to outline the monitoring and documentation of nutritional intake.

31. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at

intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The policies out line above to be reviewed by the service provider and necessary amendments to be completed

Proposed Timescale: 31/01/2016

Theme: Use of Information

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

Incomplete medication administration records were maintained.

32. 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:

All medication records to be completed and maintained at a high standard with any discrepancy to be reported and followed up on as per the medication management policy within Cheshire Ireland.

Proposed Timescale: 16/12/2015