

**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-0003456
Centre county:	Wicklow
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Julie Pryce
Support inspector(s):	Conor Dennehy
Type of inspection	Announced
Number of residents on the date of inspection:	25
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
19 November 2015 11:00	19 November 2015 18:30
20 November 2015 09:00	20 November 2015 17:30
23 November 2015 08:00	23 November 2015 14:30

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-compliant, 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 of a designated centre operated by the Cheshire Foundation was conducted by the Health Information and Quality Authority (the Authority) following an application by the provider to register the centre.

As part of this inspection, inspectors met with managers, staff, residents and family members of residents. Inspectors observed practice and reviewed documentation such as personal plans, healthcare plans, accident and incident records, risk assessments, medication records, meeting minutes, policies, procedures and protocols, governance and management documentation and staff records.

The designated centre was made up of a large country estate like premises that spanned across four main buildings to accommodate 25 residents. The centre was set in a picturesque location with well maintained and landscaped grounds. Many residents were accommodated in self contained apartments that were closely located to the main building.

There had been a recent change in the management structure of the designated centre, including a new person in charge and an operations manager. These two managers were appropriately skilled, qualified and experienced, and both were keen to outline their plans for improvement in the service.

Already some improvements had been made, for example, in the approachability of managers, in the management of complaints and in consultation with residents. However there was a high level of non-compliance, in particular in relation to the management of residents' finances, in safeguarding and in meeting the social needs of residents. Of the 18 outcomes examined during the course of the inspection there were seven major non-compliances and four moderate non-compliances. Compliance was only achieved in four of the outcomes.

These issues are further discussed in the body of the report and in the action plan at the end.

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:

Inspectors found evidence of consultation with residents and of the promotion of residents' rights and dignity in this centre. There had been substantive work completed since the changed management structure was recently introduced. Inspectors found specific improvement in the area of logging, recording and the following up on complaints. However, inspectors found further improvement was required in the area of residents' privacy.

There were various forms of consultation with residents in place, including a monthly residents' meeting and regular individual discussions. Some residents were involved in managing and supervising the volunteer programme that operated in the centre, while others formed part of the interview boards that recruited staff and management in the organisation. Residents were observed moving freely throughout the centre and liaising with staff regarding their support needs, and all residents engaged by the inspectors reported that they were satisfied with the level of consultation. One resident described an issue that had been raised at a residents meeting, and reported that the agreed actions had been implemented by staff.

Information on independent advocacy was available in the centre as was information on rights, independence and complaints.

Inspectors found that the management of complaints had been subject to considerable attention by the new management, including the relocation of offices to ensure accessibility of management to residents. Some family relatives highlighted discontent to inspectors with the way complaints in this centre had been managed prior to the newly

appointed person in charge. Inspectors found a clear system of complaints management was now in place that detailed the complaint and followed it through a clear and guided process. Satisfaction levels of the complainant and whether the complaint was resolved or unresolved was also found to be recorded.

Inspectors found that improvements were required in relation to residents' privacy. For example, one resident reported that the layout of their room did not afford them sufficient privacy needs as it was open plan and had curtains instead of doors. Some of the residents' apartments had no curtains on the front windows which meant personal belongings and valuables were in clear view from outside residents' apartments. Some residents could clearly be seen in their apartments from the outside areas. In addition, inspectors found a resident's apartment door was left open for no apparent reason during the course of inspection, and were concerned about both the privacy and the security needs of the resident.

Judgment:
Substantially 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):

No actions were required from the previous inspection.

Findings:

The inspectors were satisfied that there were structures and processes in place to facilitate communication with residents. For example, there was a system in place for staff to communicate with a resident who was deaf and blind, and while one member of staff was working on developing this system, all staff were aware of the current communication strategies.

There was a communication plan in place for those residents who had particular needs in this area which outlined guidance for staff in communicating with them.

There was a discussion about communication at a recent residents' meeting, where residents had requested changes in the way information was conveyed to them. All the actions agreed at this meeting to resolve the identified issues had been implemented.

Residents were supported to use assistive technology, for example, one resident with limited mobility used a tablet to communicate and another had been assisted to acquire an easy-use mobile phone.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:

Inspectors met a number of families and reviewed family questionnaires as part of this inspection. Families were encouraged to visit the centre and they did so on a daily basis in some cases. Residents' families were overall complimentary with the service and many of them reported that recent management changes were welcome.

Inspectors found that residents and families were encouraged and supported to develop and maintain relationships where possible. Family members were observed visiting their relatives and spending time in their apartments and in communal areas. Family members engaged by the inspectors were very aware of the care offered in the centre, and whilst they could identify positive areas, they also reported shortfalls in some areas, in particular in the area of activities and social care needs. They stated that the new management structure was a positive development, and that they felt that the new person in charge was approachable.

Inspectors were concerned about the lack of links with the local community for the majority of residents. Only a small number of residents had meaningful opportunities to engage in their community. Apart from a trip into the village on a Saturday evening for a few residents, many had little to no engagement with their community. Some residents stated this was a problem for them as there were too few activities, and that they felt lonely. Inspectors noted that residents articulated this issue in their residents meetings and forums. This issue is discussed in more detail in Outcome 5.

Judgment:
Non Compliant - Moderate

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:

Written contracts of care for full time residents were in place. However, these contracts did not refer to any charges incurred by residents as required by the regulations. For example, residents were paying separately for various services including staff escorts, transport, pharmacy services and meals, but these charges were not outlined in the contracts. There was also evidence of residents paying for fixtures and fittings including patio doors and paintwork and for basic equipment such as a commode. These additional items, which residents were required to pay for, were not mentioned in their contracts.

There were no contracts of care in place for users of the centre's respite service.

Judgment:

Non Compliant - Major

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Inspectors were not satisfied that residents' social needs were met. There was an emphasis in the centre on medical and physical needs. A reliance on volunteers to support residents' social care needs had resulted in negative outcomes for residents when a group of volunteers became unavailable to the service.

Residents and their families reported that there were insufficient activities, and some told inspectors that they felt bored and lonely. Staff also reported that there was not enough time for them to engage in social activities, or in meaningful interaction with residents.

Personal plans were in place for all permanent residents. These plans included assessments and plans relating to the activities of daily living and healthcare needs. All aspects of healthcare delivery examined by the inspectors were included. There was evidence that the plans had been reviewed at least annually.

There was a section in each of these plans entitled 'support for a meaningful day'. However, for the most part, either these plans were not implemented or the goals were not appropriate. For example, plans for social care included activities such as going to mass with family, using the hydro pool and having a cup of tea with staff. None of these goals had been implemented. In addition, there had not been appropriate goals identified for all residents. For example, the goals in the personal plans examined by inspectors included 'I don't have any aspirations' and 'to have my insulin every day'. The documented goal for one of the residents was 'to live out my days in the centre', although staff could report that this person had repeatedly expressed the wish to have a particular social outing arranged. This was not recorded and no steps had been taken towards this aspiration.

A recent occupational therapy report for a resident recommended that the resident should be up out of bed and sitting in a chair for four hours per day, but this was not taking place. The resident's identified preferred activities included going to a garden centre, having a hand massage and going for a walk in the grounds. None of these things had taken place.

The emphasis of the personal plans was on the healthcare needs of residents, despite this failing having been identified at two previous inspections. In addition there were no personal plans in place for respite service users, and there were no meaningful activities organised. One resident engaged by the inspector reported that he had not left the centre in the four days since the beginning of his respite stay, and that this was not his choice.

Several residents reported that there were insufficient drivers available in the centre to ensure transport for activities or outings.

Judgment:

Non Compliant - Major

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:

This designated centre was made up of a large, country estate like premises that spanned across four buildings to accommodate 25 residents. The centre was set in a picturesque location with well maintained and landscaped grounds. The centre was found to be mainly in a good condition but a number of improvements were required to meet the requirements of the Regulations.

There was a main house building which primarily comprised offices, volunteer accommodation and a physiotherapy room. The main building also included a communal dining room and a spacious and comfortable living room. There was a hydro pool available, however, its use was limited because of the lack of available staff to support residents to avail of it.

Many residents were accommodated in self contained apartments that were closely located to the main building. Two of these 15 apartments accommodated two residents each and the remainder were individual homes. Inspectors found that, for the most part, these apartments were meeting residents' individual needs. However, some of the apartments were not of a sufficient size to meet the needs of residents. For example, one resident's bathroom was inaccessible unless the bed was moved, and in another apartment the phone was inaccessible unless the bed was moved. Both residents of these apartments had limited physical ability to move their beds out of the way.

Some residents had adapted their environments to their needs in this regard. For example, one resident had the internal doors removed to facilitate movement through the apartment, and was now very happy with the environment and space.

One resident had inadequate storage space for personal belongings, including the storage of a wheelchair beside the toilet. The resident told inspectors that this impeded access. Many residents were using large, power pack electric wheelchairs which made accessibility in these small apartments difficult. In addition, one resident's apartment was observed to be in need of paint and repair to walls, doorframes and panels.

Inspectors found individual and wall mounted call bell alarms available to residents. When activated during the course of the inspection they were answered in a timely fashion. However, one resident told inspectors that the individual call bell was not currently available and the wall mounted one was out of reach.

There was an additional house on the campus which provided accommodation to three residents availing of respite care at any one time. This house was in a reasonably good condition and was warm and homely. Large assistive bathrooms were available in each room. A wood burning stove was observed and the residents informed the inspector that they enjoyed coming into the centre for respite breaks. However, the paintwork in the hallway of the house was scuffed and in need of maintenance.

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):

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

Findings:

The inspectors found that there were some structures and processes in place in relation to the management of risk. For example, the risk management policy now contained all the information required by the regulations, and many individual risk assessments for residents had been put in place. However further improvement was required in the areas of risk assessment and management, managerial oversight of risk, risk education amongst the staff team and clear fire evacuation guidance in all parts of the designated centre.

Inspectors found a Safety Statement dated 2015, a Risk Management Policy and Infection Control Guidelines available in the centre.

A risk register had been commenced which included some of the identified risks such as risk of falls, burns and choking but this required further attention. There was, as yet, no comprehensive oversight of all hazards and risks outlined in the risk register. In addition, not all staff were aware of this risk register or its contents. Not all staff engaged by the inspectors could identify risks outlined in the risk register, or the control measures required, for example in the management of the risk of falls.

Inspectors found that the health, safety and welfare of residents was promoted and protected in this centre. For example, there was evidence of appropriate actions following some of the incidents recorded and reported. For example, a recent fall had been followed up with full risk assessment and falls management plan. Another incident involving a resident who had a suspected choking incident had been followed up with an appropriate speech and language therapy assessment, and guidance was now available for staff relating to the management of this risk.

However, not all recorded incidents had resulted in a full risk assessment and management plan. For example, a resident who had recently fallen was identified as requiring a full review and risk assessment for safe transferring. This had not taken place. Another incident record reviewed by inspectors indicated that a resident had been found with bruising on the right hip. There was no evidence that any appropriate follow up had taken place with this resident regarding these injuries, although follow up including the requirement to conduct an assessment of the resident were recommended in the incident report.

Inspectors found there was some evidence that fire safety was managed appropriately. Fire orders were on display throughout the centre, emergency lighting was operational and fire exits unobstructed. Fire drills were carried out on a regular basis and clearly documented. Staff fire training was up to date for staff in most areas of the centre, however there were gaps as outlined below. Emergency evacuation procedures were understood. Each resident had a personal emergency evacuation plan in place, including those residents who required bed evacuations and equipment assisted evacuations.

However, inspectors found that the fire orders were either not fully clear, or were not understood by staff in the respite centre. For example, the orders required the checking of various zones, but staff could not identify where these zones were. Not all the staff allocated to the respite service were in receipt of up to date fire training.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

There had been some improvements since the last inspection in behaviour support for residents who required it. There was a plan in place for each resident who required one. Each plan was based on a thorough assessment and gave clear guidance to staff. All staff engaged by the inspectors could describe the contents of these plans, and the strategies for each resident. The implementation of the plans was documented appropriately.

The management of restrictive interventions was for the most part appropriate and there was evidence of alternatives to restrictions having been considered. For example, the use of bedrails for one resident had been reviewed, and in consultation with the resident a trial period of removing the bedrails had been implemented. This resulted in the permanent removal of the bedrails. Other residents had been consulted about the use of restrictions, and signed consents were available. However, there was conflicting information in the personal plan for one resident with regard to the frequency of checks during the use of a restriction, and the recording chart on which these checks were to be documented did not include the resident's name.

Inspectors were concerned about the management of residents' finances in the centre, particularly in the light of several recent allegations that money had gone missing. There were 'money management' plans in place for residents, and the plans for those residents who had recently had concerns about their money management had been modified to increase the safety of practices. However, these changes had not been made for any other residents, and the practices which had been considered insufficient to safeguard some residents were still in place for others.

There was a robust record keeping system in relation to all transactions in the centre, and all balances checked by the inspector were correct. However, there was no clear guidance to staff or residents as to what charges were applied. For example, staff and residents reported that residents paid for the meals, snacks and drinks for staff if they were accompanied on an outing. There was no policy or guideline to support this practice, and no mention of it in the contracts of residents.

In addition residents were paying for fixtures and fittings in the designated centre, and for essential equipment, again in the absence of any guidance. For example, residents had paid for paint and floor coverings in their apartments. Another resident who could not access the toilet in the accommodation because of mobility needs had purchased a commode in order to have toilet facilities. Inspectors were concerned that these practices were not sufficiently robust to protect the residents from financial abuse.

There was no system of auditing of finances in the centre, as further discussed under outcome 14.

Inspectors were concerned that security systems were not robust. This issue had been highlighted in the minutes of meetings held in the centre, but no action had yet been taken. This was discussed in detail with the person in charge at the close of the inspection. At the request of inspectors the person in charge gave assurances shortly after the inspection that this matter had been appropriately addressed.

Inspectors were not satisfied with the management of allegations of abuse in the designated centre, in that the emphasis was on the disciplinary procedure rather than on safeguarding of residents. Where an allegation of abuse had been upheld, inspectors were not satisfied that adequate control measures had been put in place to ensure that residents were protected from the risk of abuse. Other than invoking the disciplinary procedure, no additional control measures had been introduced, and there was no evidence of subsequent monitoring to ensure the safeguarding of all residents.

Judgment:
Non Compliant - Major

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:

The person in charge was aware of his responsibilities relating to notifications to the Authority, and all notifications had been made appropriately.

Judgment:
Compliant

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:

For the most part residents did not have sufficient access to meaningful activities. There was an emphasis in the designated centre on physical and healthcare needs, and basic social care needs were not being met. For example, preferred activities identified for residents including church attendance, hand massage, sharing a cup of tea or an outing to a garden centre were not facilitated.

Residents and their families said that there was not enough to do, and staff agreed that they did not have the time to facilitate many of the social needs of residents. Several residents were spending significant periods of time alone in their accommodation.

Any goals reviewed by inspectors in personal plans related mostly to healthcare, and there was no evidence of aspirational goals. The goals for one resident were described as 'I don't currently have any goals', although staff who knew this person could report that she had long wanted to be involved in a particular activity with her family, but that this had not been facilitated. There was no evidence of opportunities for training or education being offered or facilitated.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:

There was evidence of structures and processes in place in relation to residents' healthcare needs. Health assessments were conducted annually, and included detailed information including a history of the healthcare needs of residents. Residents had access to healthcare professionals in accordance with their assessed needs, for example, speech and language therapist, physiotherapist and general practitioner. Healthcare plans were in place in relation to the assessed needs of residents for the most part and were in sufficient detail as to guide staff. For example, there were plans in place in relation to the management of epilepsy, diabetes and skin integrity for various residents.

However, some of the goals in the plans were inappropriate or vague, as discussed under outcome 5, for example, one of the goals was 'I need to be encouraged to have a high fibre diet'. This goal was insufficient to guide staff, and the kitchen staff had not been made aware of it.

For the most part the recommendations of healthcare professionals had been implemented. For example, the recommendations of the physiotherapist for one resident had resulted in the healthcare plan being updated immediately, and the recommendations being implemented.

However, the recommendations of the speech and language therapist in relation to the management of swallow difficulties for one resident had not been documented appropriately, and were not being implemented.

All staff engaged by the inspectors were aware of the healthcare needs of residents, and could describe all the current interventions. They were also aware of appropriate infection control practices, and could describe the steps required to ensure the safety of residents in relation to the protection of residents against infection.

The implementation of healthcare was documented appropriately. For example, recording charts were in place for stoma care, catheter care and recording daily blood sugar levels.

In addition, a recent accident had resulted in a wound which required extensive nursing care. This had been managed appropriately in the centre, to the extent that at the time of the inspection it was almost completely healed.

There was evidence that a nutritional diet was offered to residents, meals and snacks including fresh fruit were readily available. Meals served to residents looked appetising, and there was a choice of at least two different courses at each meal. Residents told inspectors that they enjoyed the meals.

With the one exception mentioned above, the recommendations of healthcare professionals and resultant care plans in relation to dietary intake were available in the kitchen. Catering staff were knowledgeable in relation to these needs. In addition they had received relevant training, for example, in the management of dysphagia.

Judgment:
Substantially Compliant

Outcome 12. Medication Management

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

Theme:
Health and Development

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

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

Findings:

There were systems in place in relation to the management of medications, for example, there were appropriate structures and process for the ordering, storage, administration and stock control of medications. All staff involved in medication management had been trained in the safe administration of medications.

Prescriptions contained all the information required by the Regulations, including instructions relation to the crushing of medications where appropriate. Prescriptions for PRN (as required) medications included instructions as to the conditions under which the medications should be administered, and where necessary there was a corresponding

protocol with more detailed guidance. Administration was appropriately recorded, and a signature bank of all staff signatures was maintained.

Where residents were managing their own medications, self medications risk assessments were in place.

However, there was inconsistent practice in relation to rescue medication for epilepsy for one of the residents. This medication was prescribed for use in an emergency, and a protocol in the personal plan of the resident directed staff to take this medication with them when the resident was out and about. However, staff reported that sometimes the staff member who was accompanying the resident was not trained in the administration of medications, in which case the medication was not taken with them. While staff reported that the medication had not been required for some time, there was no clear written guidance relating to this, and no corresponding risk assessment to support the decision that was being made on a regular basis.

Judgment:
Substantially Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A statement of purpose was in place in accordance with the regulations, and this document accurately described the service provided by the designated 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:

Inspectors found that this centre was going through a significant change process following the introduction of a new management structure, which had been in place for approximately five months at the time of the inspection. There had been some areas of substantial improvement noted since the previous inspections, however further improvement was required relating to both the responsibilities of local management level and the responsibilities of the registered provider to ensure regulatory compliance in the designated centre.

Inspectors found the centre was a very rural and long standing centre whereby care had clearly been delivered in a set way for many years. Care was provided to residents in a kind and considerate way by staff who knew them very well. However, many staff were not aware of their responsibilities in relation to the standards and regulations.

The person in charge was found to be a qualified and professional manager with extensive relevant experience in the area. He worked full-time and had been in post just five months at the time of inspection. The person in charge had clear evidence of the changes and developments to areas such as consultation, safeguarding and complaints management in the centre. The person in charge was appropriately qualified and had relevant and experience in management.

The person in charge was supported by an equally qualified and professional operations coordinator who had implemented training schedules, performance management of staff and was engaged in ongoing improvements of the staff rostering systems.

However, significant areas of non-compliance with the regulations were identified during the course of the inspection, as discussed throughout the report. Further oversight and robust management was required to ensure the appropriate delivery of care to residents, particularly in the areas of risk management, social care needs, quality of life and safeguarding. For example, auditing of centre was either scarce, or not robust.

There was no evidence of any unannounced visits having been conducted on behalf of the provider, as required by the regulations, or of an annual review of the quality and safety of the care and support of residents. Following the last inspection, it was agreed that these actions would be complete by the end of June 2015, but this was not the case.

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:

The person in charge was aware of his responsibilities in relation to notifying the authority of absences, and appropriate deputising arrangements were in place in the eventuality of any absences.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

The centre was not appropriately resourced to ensure the effective delivery of the care and support needs of all residents. For example, there were insufficient staff to appropriately meet residents' needs, parts of the premises were inappropriate to the needs of residents and there was insufficient transport available to residents. In addition there was ambiguity around charges to residents, in particular in relation to fixtures and fittings, and basic equipment such as a commode.

Inspectors also reviewed the financial resources of the centre and noted that only €150 per month was allocated to social activities in this centre which accommodated 25 people. The poor standard of care in relation to social care needs and social activities was outlined in outcome 5 and outcome 10.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

There were insufficient numbers of staff and skill mix to meet the needs of all residents. This was identified as a failing at the previous two inspections of the centre. The operations manager outlined steps that had been taken in relation to recruitment and to providing an additional nursing post, but at the time of inspection staff resources were inadequate.

Inspectors found that at 11am the staff numbers were significantly reduced, and were not sufficient to both support residents at mealtimes and to provide appropriate social activation. Residents were observed to be awaiting assistance with other activities whilst others were having their meals. Staff, residents and family members all reported that they believed that residents did not have appropriate access to socialisation and activities because of staffing levels.

Several volunteers had recently left the service, and this was having a significant impact on service provision. Inspectors found that the centre had relied almost exclusively on these volunteers to meet the social care needs of residents. There was no contingency plan in the event of the absence of volunteers and the gap in service subsequent to their leaving had not been met. Staff, residents and families all referenced this issue to inspectors. It was also highlighted in documentation such as the complaints log and the minutes of residents' meetings.

A number of residents told inspectors that it would be nice if staff would come and have a cup of tea with them or a chat with them. Families highlighted that while the individual apartments were a good concept, residents were frequently lonely and that staff sometimes did not have the time to spend with residents.

The operations coordinator had devised and implemented an improved rostering system that was intended to be more needs focussed, and planned and actual rosters were available. However, resources placed severe limitations on the effectiveness of this. Additional work had also been completed in terms of training needs analysis, training schedules and supervision and performance management.

Not all of the information required by the Regulations was in the staff files. For example, photographic identification and references were missing from some of the staff files reviewed by the inspectors.

Staff were observed as caring and considerate in their role during the course of the inspection, and had detailed knowledge of the residents and their needs. However, many were not informed in relation to the regulations and standards, or in relation to the required actions from the previous inspection.

Staff training records were reviewed by the inspectors, and all mandatory training was up to date. In addition, staff had received training in aspects of care delivery relevant to the assessed needs of residents, including epilepsy management, catheter care and bowel care. Staff engaged by the inspectors were knowledgeable in these areas.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

A directory of residents was in place for those residents who resided in the centre full time, which included all the information required by the regulations. However, whilst some charges were outlined in this directory, not all were included. For example, the requirement for residents to pay for transport was included, but the need to pay for staff escorts was not. In addition, there was no directory in place for those residents availing of a respite service in the centre.

All the policies required under schedule 5 of the regulations were in place. However, these were for the most part organisational policies, and further local guidance was required in relation to the management of residents' finances, as discussed under outcome 8. In addition, staff were not aware of the policy relating to the use of CCTV in the centre.

Judgment: Non Compliant - Major

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:

Julie Pryce
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-0003456
Date of Inspection:	19 November 2015
Date of response:	11 February 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:

Residents' privacy was not adequately promoted in relation to personal space and security.

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

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

- A review of all Resident's homes is underway regarding open plan living arrangements. Remedial work will be undertaken, according to the wishes of the resident, to ensure that maximum privacy and dignity are afforded to each resident.
- All residents homes have venetian blinds on front windows and doors. Residents will be offered lace curtains for all windows in their homes.
- All home safes have been moved ensuring that no home safe can be seen from outside.
- Five residents have automated front doors on their houses. Costings have been sought in relation to the installation of automated doors on all resident's homes. In the meantime staff and residents are being encouraged, in so far as is reasonably practicable, to ensure residents homes are locked at all times for reasons of privacy and security. Minutes of monthly meetings will reflect same.

Proposed Timescale: 30/08/2016

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

Theme: Individualised Supports and Care

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

Residents were not provided with adequate and appropriate links to the community.

2. Action Required:

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

- A review of all aspects of the Keyworker/Careplanner system within the service is underway to maximise the efficiency and usefulness of this system.
- A review of Resident's personal plans will be undertaken in conjunction with the resident and where appropriate his/her representative, in accordance to the resident's wishes. Amended personal plans will reflect S.M.A.R.T. objectives in relation to linking with the community as well as outlining how these objectives will be achieved.
- A review of how social plans/activities are arranged and recorded in a resident active file will be undertaken by the PIC and Activities Coordinator with the aim of making this information more accessible.
- Regular Social planning meetings will be introduced into the schedule of meetings, overseen by the PIC, Operations Coordinator or Activities Coordinator.
- A review of the current role of the existing Activities Coordinator will be undertaken

by the PIC to ensure that the person in this position is enabled to concentrate solely on issues related to activities both within the service and in the wider community.

- Training will be sought for and offered to the Activities Coordinator specific to this unique role.
- A social planning ideas box will be introduced into the service. All staff and residents will be encouraged to place ideas for social activities and linking with the community into the box.
- Staff involved in the social programme in the designated centre will visit other Cheshire centres to explore how their residents develop and maintain personal relationships and links with their communities.
- Having adequate staff numbers is essential to success in this outcome. As detailed under Outcome 5 the PIC and Operations Coordinator are working towards
- Re-establishing the centre's volunteers programme to facilitate opportunities for new experiences, social participation, training and employment for residents.
- Increasing staff numbers (via extra core funding from statutory agencies – see outcome 5) and altering roster arrangements (as per roster review group –see outcome 5) to maximise availability of staff for social activities
- New Community Employment posts have commenced in the area of Activities
- A relief staff for all disciplines is established and under development

Proposed Timescale: 30/06/2016

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:

Written contracts of care were not in place for respite residents.

3. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

- A working group led by the Service quality team have completed a standard contract of care specific to Respite Service Users.
- Following a small amount of training for staff, Contracts of Care for Respite Service Users will be implemented on an "on admission" basis i.e. as people use the respite service, so their contract of care will be completed and signed, a signed copy will then be kept in the Service User's active file.

Proposed Timescale: 31/12/2016

Theme: Effective Services

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

Written contracts of care did not include charges incurred by residents.

4. 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 person in charge will implement an addendum to the current Resident Service Agreement which will outline fees to be charged in relation to extra services provided by the Service to the Resident such as transport, meals, private hours etc.
- Currently the Service Agreement for Residents is under review by the person in charge along with the Service Quality Team to ensure the agreement complies with regulatory requirements.
- Tenancy agreements and Cheshire policies will be reviewed by the person in charge supported by the finance department and the service quality team in relation to residents paying for fixtures and fittings.

Proposed Timescale: 30/06/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Residents availing of respite services did not have personal plans.

5. 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:

- A working group led by the Service quality team have completed a personal plan specific to Respite Service Users.
- Following a small amount of training for staff in the completion of a personal plan, all users of Respite Services will be supported by Nursing and Care staff to develop a personal plan. This work will be done on an "on admission" basis ie as people use the respite service, so their personal plan will be completed and signed.

Proposed Timescale: 31/12/2016

Theme: Effective Services

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

Arrangements were not in place to meet the social needs of residents.

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:

- A review of Resident's personal plans will be undertaken in conjunction with the resident and where appropriate his/her representative, in accordance to the resident's wishes. Amended personal plans will reflect S.M.A.R.T. objectives as well as outlining how these objectives will be achieved.
- The Person in Charge is working with a dedicated group of service managers and central office staff to re-establish the volunteer programme. Successful registration with the Leargas programme needs to be achieved by April to facilitate an October intake of volunteers. Should registration be achieved, the designated centre would apply for four volunteer positions which would be used to directly address the social needs of residents.
- The person in charge and the operations coordinator supported by the finance department are examining the current needs analysis of several residents with the aim of highlighting to the various statutory agencies involved the need for greater funding/staffing levels. Such funding would address staff shortages at particular times of the day
- A panel of relief staff is now available in the service. All disciplines will be represented on this panel including care staff and drivers.
- Two new Community Employment positions (1 WTE) have commenced in the area of Activities, reporting directly to the Activities Coordinator. Recruitment to the CE scheme is ongoing.
- The management of all types of leave has been and continues to be increased through the implementation of systems in relation to leave planning, absence monitoring, performance management etc
- A full review of contracted staff hours versus required staff hours is underway to identify understaffing/overstaffing in the care area compared to budgeted hours available.
- The roster review group continues to meet with the aim to devise and implement a rolling roster for care support workers.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

Supports required to maximise the personal development of residents were not outlined.

7. Action Required:

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

- A review of all aspects of the Keyworker/Careplanner system within the service is underway to maximise the efficiency and usefulness of this system.
- A review of Resident's personal plans will be undertaken in conjunction with the resident and where appropriate his/her representative, in accordance to the resident's wishes. Amended personal plans will reflect S.M.A.R.T. objectives as well as outlining how these objectives will be achieved.
- The Person in Charge will audit the personal plans of residents to ensure that identified goals are being achieved and recorded.
- Driver training is available to all staff in the centre in order to maximise the number of staff available to drive. Staff are being encouraged to take part in this training as soon as possible.
- Recommendations by the Occupational Therapist in relation to one resident will be clarified and implemented in so far as is reasonably practicable.

Proposed Timescale: 30/06/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Not all parts of the designated centre were fully accessible.

8. Action Required:

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

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

- The person in charge supported by the maintenance team will carry out an accessibility audit of the designated centre.
- Remedial work stemming from the accessibility audit will be undertaken.
- One apartment has had an extra telephone point installed to allow for ease of access for the resident.

Proposed Timescale: 31/08/2016

Theme: Effective Services

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

Not all residents had access to a call bell.

9. Action Required:

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

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

- The arrangements for each resident to access a call bell, both at night and during the day will be recorded in the resident's care-plan and will be known by all staff.
- The absence of a call bell, a malfunctioning call bell or an inaccessible call bell will give rise to an Adverse event form.
- The person in charge will audit the call bell arrangements periodically.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

Not all the matters set out in Schedule 6 were in place regarding room size, suitable storage and accessibility to bathrooms.

10. 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:

- A new system of property folders is to be introduced. Each residence will have an individual property folder detailing maintenance, upkeep, home improvements etc.
- The person in charge supported by the maintenance team will carry out an accessibility audit of each residence, taking into account storage issues.
- Remedial work stemming from the accessibility audit will be undertaken.
- A storage room will be provided for residents. This will be a locked room where residents can store personal items safely. Each item put in or taken out will be recorded and signed for.
- The Respite Service Hallway has been fully painted.
- Some remedial work has been completed in one resident's home which is in need of upgrading as identified during inspection. Full refurbishment of this residence will be completed.

Proposed Timescale: 31/08/2016

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:

There were not robust systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

11. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

- A gap analysis is currently being undertaken by the Health and Safety Officer on The Risk Management and Safety Management system within Cheshire Ireland. On review of this, the risk management system will be revised and implemented.
- Safety Representative training program is being drafted and the safety representative training will be available to staff at the centre. This will give the safety representative the tools required to assist him/her to carry out this function while ensuring the risk culture is communicated and corrective actions are put in place to remove the risks.
- Health and Safety Officer will conduct training for staff around how to conduct risk assessment. This training will be on-going to drive the safety culture and the importance of risk elimination.
- Health and safety meetings to be held monthly high-lighting the importance of risk communication. Reduce risk and eliminate risk when possible.
- The Health and Safety Officer, Person in charge, Staff, and the safety representative to conduct the following risk assessments which in turn will aid the service in managing risk throughout the service:
 - Site specific risk assessments
 - Generic risk assessments
- Risk management training to be undertaken with key staff in the service.
- Health and safety training to be given to staff in the service to assist with on-going improvements in safety culture and communication throughout the service.
- A Self-Assessment Health & Safety Audit tool has been drafted by the new Health and Safety Officer (HSO). The Person in charge will complete this audit bi-monthly and send to the HSO for review. This audit tool will assist the service to ensure health and safety auditing is on-going. Both the Health and Safety Officer and the Person in Charge will review the risks together in the service. The following areas will be audited: safety, fire safety, security, food safety and compliance documentation.
- Unannounced and announced risk management audits will be undertaken on an on-going basis by the Health and Safety Officer. Findings and results of these internal audits will allow Cheshire Ireland to determine if the new safety practices, life safety systems and emergency plans are operating and facilitating the service correctly.
- The Person in Charge will undertake a review of the Emergency Response system in both the main building and in the Respite Service

Proposed Timescale: 31/12/2016

Theme: Effective Services

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

Not all staff were in receipt of up to date with fire training.

12. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

- All staff currently working in the designated centre hold up to date fire training. New staff will be trained at the earliest opportunity.

Proposed Timescale: 11/04/2016

Theme: Effective Services

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

The fire precautions in the all parts of the designated centre were not appropriately reviewed.

13. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

- All staff currently working in the designated centre hold up to date fire training.
- A floor plan of the respite service has been drawn up showing call points, emergency exits, fire extinguishers, alarm panel and assembly point. A floor plan has been placed in each room.
- A review of the fire zones in the respite service has been performed. It was discovered that all areas show up as Zone 1. The emergency evacuation procedures for the respite service are being reviewed in light of this information.

Proposed Timescale: 11/04/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Not all restrictive practices were recorded appropriately

14. 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:

- Conflicting information in the personal plan for one resident with regard to the frequency of checks during the use of restriction has been rectified and all records of checks have the residents name and details in place.
- The Person in charge will audit restrictive procedures within the service on a regular basis.

Proposed Timescale: 31/05/2016

Theme: Safe Services

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

Arrangements for the protection of residents' finances were not robust

15. Action Required:

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

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

- All money management plans for residents will be reviewed by the person in charge supported by the administrator, the quality team and the finance department.
- Currently the Service Agreement is under review by the person in charge along with the Service Quality Team to ensure the agreement complies with regulatory requirements.
- The person in charge will implement an addendum to the current Service Agreement which will outline fees to be charged in relation to extra services provided by the Service to the Service User such as transport, meals, private hours etc.
- A Cheshire working group including the Person in charge is meeting to produce a holiday policy, including details of charges incurred by residents around holidays.
- Similar policies are planned for outings and transport charges.
- Tenancy agreements and Cheshire policies will be reviewed by the person in charge supported by the finance department and the service quality team in relation to residents paying for fixtures and fittings.
- The person in charge supported by the finance department will develop a system of internal audit of finances in the centre.

Proposed Timescale: 31/07/2016

Theme: Safe Services

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

The management of allegations of abuse was inadequate to ensure the safeguarding of residents.

16. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

- The person in charge will ensure that any future allegations of abuse are dealt with according to Cheshire Ireland Adult Protection Policy and Abuse Reporting and Investigation Procedures, supported by HSE National Policy and Procedures – Safeguarding of Vulnerable Persons at Risk of Abuse.
- The person in charge will ensure that when dealing with any future allegations of abuse, priority is placed on the implementation of adequate control measures to ensure the safeguarding of all residents.
- Increased one to one performance management sessions and a ban on lone working may be some of the measures used where an allegation of abuse has been upheld.
- The person in charge will discuss with the Regional manager, the service quality team and the Human Resource Department the case where an allegation of abuse was upheld to explore if control measures and increased monitoring are appropriate at this time.

Proposed Timescale: 11/04/2016

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:

Residents were not provided with access to appropriate opportunities.

17. 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 service must begin by identifying the wishes of the residents in relation to accessing education, training and employment opportunities. To this end a review of Resident's personal plans will be undertaken in conjunction with the resident and where appropriate his/her representative, in accordance to the resident's wishes. Consideration will be given to the resident's age and past training/employment history. Amended personal plans will reflect S.M.A.R.T. objectives in relation to accessing

education, training and employment opportunities as well as outlining how these objectives will be achieved.

- A review of how social plans are arranged in a resident active file will be undertaken by the PIC and Activities Coordinator with the aim of making this information more accessible.
- Regular Social planning meetings will be introduced into the schedule of meetings, these meetings will be overseen by the PIC, the operations coordinator or the Activities Coordinator.
- A review of the current role of the existing Activities Coordinator will be carried out by the PIC supported by the HR department to ensure that the person in this position is enabled to concentrate solely on issues related to activities both within the service and in the wider community.
- Training will be sought for and offered to the Activities Coordinator specific to this unique role.
- Staff involved in the social programme in this designated centre will visit other Cheshire centres to explore how their residents access opportunities for education, training and employment.
- Having adequate staff numbers is essential to success in this outcome. As detailed under Outcome 5 the PIC and Operations Coordinator are working towards
 - Re-establishing the centre's volunteers programme to facilitate opportunities for new experiences, social participation, training and employment for residents.
 - Increasing staff numbers (via extra core funding from statutory agencies – see outcome 5) and altering roster arrangements (as per roster review group –see outcome 5) to maximise availability of staff for social activities
 - New Community Employment posts have commenced in the area of Activities
 - A relief panel for all disciplines is established and under development
 - Once resident's goals are clarified, the Activities Coordinator and Keyworker will support the resident to access appropriate agencies for training/education and employment opportunities.

Proposed Timescale: 30/06/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Not all healthcare recommendations had been implemented.

18. Action Required:

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

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

- The person in charge will inform all care staff that residents goals in care plans should be S.M.A.R.T. goals

- A review of personal care plans will be undertaken by nursing and care staff to ensure that goals are S.M.A.R.T. and that all recommendations of Healthcare professionals have been implemented.
- A goal referring to a high fibre diet on one resident's file has been adjusted appropriately.
- Recommendations by the Speech and Language Therapist in one resident's care-plan which had previously not been implemented have now been implemented fully.

Proposed Timescale: 30/06/2016

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:

There were not always suitable practices in relation to administration of medication.

19. 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:

- While nursing staff audit the medication management system quarterly, the person in Charge will also audit the medication management system periodically.
- One resident around whom there was inconsistent practice in relation to rescue medication for epilepsy has been reviewed by his GP and discontinued on this medication.
- Procedures for the management of rescue medication within the centre are being reviewed by the person in charge and the nursing staff supported by the Cheshire Clinical team. The appropriate risk assessments will be put in place.

Proposed Timescale: 30/06/2016

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:

Care provision was not effectively and consistently monitored.

20. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

- A comprehensive meeting structure already exists in the centre through which feedback on service quality is received from both staff and residents.
- A robust complaints system is in place.
- A robust system of recording and analysing adverse events has been in place since 1st January 2016
- A gap analysis is currently being undertaken by the Health and Safety Officer on The Risk Management and Safety Management system within Cheshire Ireland. On review of this, the risk management system will be revised and implemented.
- A Self-Assessment Health & Safety Audit tool has been drafted by the Health and Safety Officer (HSO). The Person in charge will complete this audit bi-monthly and send to the HSO for review. This audit tool will assist the service to ensure health and safety auditing is on-going. Both the Health and Safety Officer and the Person in Charge will review the risks together in the service. The following areas will be audited: safety, fire safety, security, food safety and compliance documentation.
- The Person in Charge is systematically developing and introducing systems of audit into the service, in areas such as medication management and personal plans, the aim being to develop a comprehensive system of auditing all aspects of the service spanning the calendar year.
- A service user questionnaire/survey is currently being drafted by Service Quality Team and feedback from the survey will be reviewed to ensure the service we provide is safe and appropriate to resident's needs.

Proposed Timescale: 31/12/2016

Theme: Leadership, Governance and Management

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

There was no annual review of the quality and safety of care and support in the designated centre.

21. 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:

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

- An annual review template has been developed and implemented.
- An annual review of the quality and safety of care and support in the designated centre will be completed by the PIC.

Proposed Timescale: 15/05/2016

Theme: Leadership, Governance and Management

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

There was no evidence of unannounced visits on behalf of the provider to the designated centre at least once every six months, no written reports on the safety and quality of care and support provided in the centre and no plan in place to address any concerns regarding the standard of care and support.

22. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

- One unannounced Safety and Quality Assurance audit was carried out in November 2015
- A review of the current quality audit system within Cheshire Ireland is underway. A working group has been appointed which will ensure that a robust structure of audit will be in place within the organisation. An audit tool has been developed and unannounced audits have commenced throughout the organisation. A Provider schedule of unannounced audits is in place for 2016 which includes two inspections of this designated centre.

Proposed Timescale: 31/12/2016

Outcome 16: Use of Resources

Theme: Use of Resources

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

The centre was not appropriately resourced to meet residents' needs.

23. Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

- The person in charge supported by the finance department is examining proposed changes to the staff roster in light of financial budgets and funding opportunities with the express aim of increasing staff availability for social activities. It is hoped that this process will result in a more stable staff compliment throughout the day.
- The person in charge supported by the finance department is examining the issue of the social budget.

- Driver training is available to all staff in the centre in order to maximise the number of staff available to drive. Staff are being encouraged to take part in this training as soon as possible.
- The person in charge will implement an addendum to the current Service Agreement which will outline fees to be charged in relation to extra services provided by the Service to the Service User such as transport, meals, private hours etc.
- Currently the Service Agreement is under review by the person in charge along with the Service Quality Team to ensure the agreement complies with regulatory requirements.
- Tenancy agreements and Cheshire policies will be reviewed by the person in charge supported by the finance department and the service quality team in relation to residents paying for fixtures and fittings.

Proposed Timescale: 30/06/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was not appropriate number of staff to meet residents' needs.

24. Action Required:

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

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

- A third nurse took up post in the centre on 5th January 2016 bringing the total nursing hours to 92 hours per week excluding the Head of Care's 30 hours per week.
- The person in charge supported by the finance department is examining proposed changes to the staff roster in light of financial budgets and funding opportunities with the aim of increasing staff availability for social activities and meal times, as well as affording the service a more stable staff compliment throughout the day. Some changes to the roster have already occurred.
- The Person in Charge is working with a dedicated group of service managers and central office staff to re-establish the volunteer programme. Successful registration with the Leargas programme needs to be achieved by April to facilitate an October intake of volunteers. Even in the event of the re-establishment of the volunteer programme, the PIC will ensure that the social needs of the residents are not wholly dependent on volunteers.
- A panel of relief staff will soon be available in the service. All disciplines will be represented on this panel including care staff and drivers.
- Two new Community Employment positions (1 WTE) will commence shortly in the area of Activities.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

Not all staff files included all of the required documentation.

25. 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:

- A reminder letter was sent to all staff with documents outstanding at the beginning of January 2016.
- The audit of staff files is currently being updated.
- A final request for documentation will be issued before consulting with the HR department regarding linking the absence of such documentation to the disciplinary process.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

Not all staff were not fully aware of the regulations, standards or last inspection report findings.

26. Action Required:

Under Regulation 16 (1) (c) you are required to: Ensure staff are informed of the Act and any regulations and standards made under it.

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

- All Staff have been divided into small groups of no more than ten people. Each group will meet once per month for six months. Each month will focus on three of the 18 HIQA outcomes, making links to the Regulations and Standards as well as focussing on the feedback that our centre received, under these outcomes, on previous inspection reports. These groups will be facilitated by the PIC and the operations coordinator supported by the National Learning and Development Manager.

Proposed Timescale: 31/12/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

Staff had not been made aware of the policy relating to the use of CCTV

27. Action Required:

Under Regulation 04 (2) you are required to: Make the written policies and procedures as 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 available to staff.

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

- The CCTV policy is included in the Centre's schedule 5 folder which is available to all staff in the communication room.
- The PIC has designated the CCTV policy as "policy of the month" for February 2016 meaning that all staff are expected to read the policy and sign to indicate that they have done so and understand same. This information is communicated at all meetings throughout the month.

Proposed Timescale: 11/04/2016

Theme: Use of Information

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

There was no directory of residents availing of respite service.

28. Action Required:

Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

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

- A template for a directory of users of the respite service will be developed
- The directory of users of the respite service will be completed on an "on admission" basis ie as people use the respite service, so their details will be entered into the directory.

Proposed Timescale: 31/12/2016

Theme: Use of Information

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

Not all the required information was included in the directory of residents.

29. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

- A factual accuracy form has been completed to question the requirement to include service charges within the Directory of Residents. (See Factual Accuracy – Mon-0013251)
- Currently the Service Agreement is under review by the person in charge along with the Service Quality Team to ensure the agreement complies with regulatory requirements.
- The person in charge will implement an addendum to the current Service Agreement which will outline fees to be charged in relation to extra services provided by the Service to the Service User such as transport, meals, private hours etc.

Proposed Timescale: 30/06/2016