**Health Information and Quality Authority**
**Regulation Directorate**

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland |
| **Centre ID:** | OSV-0003437 |
| **Centre county:** | Carlow |
| **Type of centre:** | Health Act 2004 Section 39 Assistance |
| **Registered provider:** | The Cheshire Foundation in Ireland |
| **Provider Nominee:** | Mark Blake-Knox |
| **Lead inspector:** | Noelene Dowling |
| **Support inspector(s):** | Gary Kiernan |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 13 |
| **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 un-announced and took place over 1 day(s).

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

| From: | To: |
|---|---|
| 08 April 2016 09:00 | 08 April 2016 18:00 |

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

| |
|---|
| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 09: Notification of Incidents |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 15: Absence of the person in charge |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

**Summary of findings from this inspection**

This was a follow up inspection to ascertain the actions a taken by the provider to address the deficits found in the registration inspection which took place in October 2015. There were a significant number of non compliances found at that inspection of which four were categorized as Major in the areas of Health and Safety, Governance and Management, Staffing and Notification to The Health Information and Quality Authority (HIQA).

Following that inspection the provider was requested to attend a meeting with HIQA to outline the concerns. In particular the finding that residents had been moved from the designated centre to a centre in the community which was not part of the application for registration was highlighted. A warning letter was issued to the provider in regard to this on 8 April 2016.This issue has been addressed with an amended application from the provider to register three of the apartments in the units involved. These three units were visited as part of this follow up inspection and to inform the registration decision.

Inspectors met with the person in charge, residents and staff, observed practices and reviewed the documentation such as personal plans, medical records, accident logs, policies and procedures and staff files.

This is a designated centre for adults with physical and neurological conditions. Centres are located across two areas. Accommodation for ten residents is located on the grounds of the original centre with a further three apartments located a short distance away in a modern housing development in the community.

The residents with whom inspectors spoke were very complimentary in regard to the service and the staff who supported them. They spoke of been enabled to be as independent as possible, able to make their own decisions regarding their choice of routines, and activities and healthcare, and of having support to maintain their health and mobility. They enjoyed the privacy and independence of the apartments. They also said they had good staff support and enjoyed being able to mix with other residents living near them.

Inspectors found that the provider had made improvements in a significant number of areas which supported residents' safety and rights. Overall, inspectors were satisfied that the provider had put system in place to ensure that the regulations were being met. This resulted in positive experiences for residents, the details of which are described in the report.

Improvements were found to have been made in:
• the workforce, numbers and skill mix (outcome 17)
• safeguarding and safety (Outcome 8)
• residents' right and consultation (Outcome 1)
• governance (Outcome 14)
Continued good practice was found in health care and medication management. There were some areas of non compliance identified in the following areas;
• consistent implementation of risk management strategies in relation to fire safety management systems which could present risks to residents (Outcome 7)
• staff training (outcome 17) This was rectified by the person in charge immediately following the inspection
• clarity in safeguarding concerns (outcome 8)
• documentation and policies (Outcome 18)

The actions required to achieve compliance with the Health Act (Care and Support of Residents in Designated Centres (Children and Adults) With Disabilities Regulations 2013 are outlined at the end of this report.

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

**Outcome 01: Residents Rights, Dignity and Consultation**
*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
At the previous inspection there was no evidence that residents had an opportunity to discuss their views or preferences in relation to their care and the service provided; documentary evidence of a legal protection order was not available to ensure the provider was complying with the requirements and it was not apparent that residents who made complaints were informed of or satisfied with the outcome or process.

All of these actions were satisfactorily resolved. Written evidence of individual discussions with the residents were available and demonstrated a willingness to address any issues and influence practices. The residents also told the inspector that they had good opportunities to raise issues and they were listened to.

The required legal documentation was available and there was evidence that the person in charge been adhering to the arrangement for the resident. A review of the complaints records showed that complaints were addressed transparently and both informal and formal complaints were recorded.

The inspector was satisfied that there was a commitment to promoting resident's rights and to providing care according to their preferences and needs. The programmes and choice of routines were primarily dictated by the residents own preferences, capacitates and agreed rehabilitative plans where this was relevant. The staff and other supports required such as adapted transport and mobility aids to ensure this occurred were made available.

There was evidence that the residents were closely involved in their personal plans with a view to achieving day to day and longer term goals. The residents informed the inspector of this and also stated that their wishes were ascertained. Residents stated that staff provided them with information and clarity so that they understand their care needs and could make informed choices. All of the apartments were single occupancy and easily accessible for residents most of whom had significant mobility issues.

External independent advocacy services had been sourced for a number of residents in the past. On this occasion it was suggested by inspectors that an advocate should be sourced for a resident to ensure the decisions being taken by other agencies were understood and of their choosing. The person agreed to undertook to address this.

**Judgment:**
Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There were two actions required from the previous inspection. The admission policy was not comprehensive and did not take account of the need to protect residents from abuse by their peers. The service agreement was not comprehensive and did not stipulate the fees to be charged in relation to extra services provided such as transport, meals, private hours and all other items the resident had to pay for in addition to the rent.

One of these actions had been resolved and the second was partially resolved. The admission policy outlined how the pre-admission assessment procedure would indicate the suitability of perspective admissions and how decisions would take account of the protection and vulnerability of other residents.

The move from the main congregated units to the community style individual apartments had been undertaken in consultation with residents with transitional plans made to support them. There were documentary systems to ensure that if residents required admission or transfer to other services detailed information was available.

An addendum had been added to the service agreements which outlined additional costs for services outside of the basic fees. Where a resident choose to seek private care hours for personal activities these were agreed, recorded and payments were audited.

However, of a sample of the service agreements reviewed not all of them stipulated the details of the services to be provided.

**Judgment:**
Substantially Compliant

**Outcome 05: Social Care Needs**
*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The previous inspection found that persons responsible for supporting residents in pursuing identified goals were not clearly identified nor were the supports available defined in the personal plans. This action was satisfactory resolved. Inspectors found that social, health and psychological care needs of residents were regularly assessed by staff and relevant clinicians. Personal plans titled "Lifestyle Plans "were made to ensure that these were followed through on. There was evidence on the records seen and from speaking with the residents that they and or their representatives were involved and consulted in regard to their care, goals and rehabilitative needs if appropriate.

In accordance with assessed needs of the residents the personal plans provided details as to the capacity for the activities of daily living and the supports which each resident required to undertake this. The plans were found to be concise and regularly reviewed with multi-disciplinary input from allied health services as required by the residents needs. Regular internal reviews also took place.

There was evidence that outcomes were reached and further plans and goals were identified in conjunction with the residents. These included gaols such as access to adapted tools such as mobile phones or computers. One resident was taking driving lessons and told the inspector that the healthcare, physiotherapy and encouragement from staff had been a significant benefit to them. There were support plans for residents' mental health including where residents had early stage dementia.

There were directions and protocol in place for the management of epilepsy and diabetes and speech and language which staff were familiar with. However, an action was identified in relation to the staff training in the event of a choking incident or the necessity for emergency medications. This is actioned under Outcome 17 workforce.

**Judgment:**
Compliant

**Outcome 07: Health and Safety and Risk Management**
*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The previous inspection found that the systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies and fire safety management procedures including the provision of alarms and emergency lighting were not satisfactory.

This inspection found that improvements had been made but further work was required to ensure effective risk and fire safety management systems including responses to fire alerts and the holding of fire drills. A risk register, emergency plan, and fire safety management plan had been implemented. There were regular checks on the fire detection system and fire equipment.

Fire drills had been undertaken and staff had received training in fire safety. The drills undertaken were not comprehensive. They did not include one of the apartments and did not replicate night time staffing levels taking the locations and dependency levels into account.

In the event of a fire in one of the units' there was still a dependency on the use of mobile phones to alert colleagues if staff needed assistance. This had been raised at the previous inspection. This will also be the case when the connecting corridor between units and the administration building is demolished in the near future. While no issues had been identified, the fire safety plan had not been risk assessed with regard to the use of mobile phones for summoning assistance.

The emergency lighting and fire alarm system had been installed since the previous inspection and there was evidence of contracted arrangements to continue servicing these. Extinguishers had also been serviced.

Staff quarters adjacent to one of the apartments were being erected at the time of inspection to ensure closer proximity to the residents and there is a fulltime staff presence in another unit of apartments some distance away.
All residents had emergency response alarms on their person which they told inspectors about.

Each resident had a and individual risk assessment completed which governed a number of issues such as medical needs, physical and behavioural limitations and building hazards. The assessments focused on individual residents' needs for example, issues with medication or potential for falls. There were strategies in place to mediate the risk.

**Judgment:**
Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There were three actions required from the previous inspection. These were the lack of specialist multidisciplinary input and subsequent behaviour support plans and staff training in the support of residents with challenging behaviours. Robust systems to protect residents from the potential of financial abuse were also required. All three had been satisfactorily resolved. Appropriate clinical assessments had been undertaken and a behaviour support plan was in the process of being devised where this was required.

The plan included the identification of specific staff to provide one to one support for a resident in the evening time in order to ensure continuity of care. These staff had been identified and the rosters were being duly altered to accommodate this. Records showed that all staff had received training from external professional in the management of behaviours that challenge. There was no p.r.n.( use as required) medication being used at the time of this inspection to manage behaviours. Records showed that where such medication had been prescribed it was monitored by the prescribing specialist. Staff also noted any adverse affects on the residents and acted in response to this. There was no evidence that this was used inappropriately.

Progress had been made to alter the previous practices whereby residents' monies were held and managed by the organisation's bank accounts. Personal bank accounts had been opened by residents and inspectors saw that fee payments and any monies debited were clearly recorded and there were auditing systems in place. Some residents required staff support to manage and access their monies. Systems were being introduced to facilitate this and also to ensure there were robust auditing and checking system in place to protect residents.

Inspectors were informed that a person with experience in safeguarding had recently been employed by the organisation and was in the process of devising an up to date policy which would ensure the correct systems were in place.

There were personal intimate care guidelines available for the residents.

The inspector was informed that no concerns or allegations of this nature were being investigated at the time of this inspection. Records reviewed showed that a historical issue (external to the centre) recently discussed with staff had been reported as required to the person in charge. However, the subsequent enquiries made in relation to this were not satisfactory to ensure that there were no current safeguarding issues for the resident in relation to the persons concerned.

There was a policy on the management of behaviour that is challenging and the use of restrictive procedures. Both were satisfactory and in line with guidelines. Such practices included lab belts and bedrails. The necessity of these practices was risk assessed and there was multidisciplinary involvement in the decisions. There was also significant involvement of the residents themselves and their preferences in the use of these.

While it was apparent that alternatives had been tried the documentations did not consistently detail the reasons they had not been successful. However, from a review of the records and speaking residents and staff the inspector was satisfied that this was a documentary deficit only and is actioned under Outcome 18 records and documentation.

**Judgment:**
Non Compliant - Moderate

**Outcome 09: Notification of Incidents**
*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
This action was satisfactorily resolved. From a review of the accident and incident logs and the notifications forwarded the inspector was satisfied that the person in charge was complying with the requirement to notify HIQA of any accidents or incident which occurred in the centre within the required timeframe.

**Judgment:**
Compliant

**Outcome 11. Healthcare Needs**
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

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

**Findings:**
There were no actions action required from the previous inspection and inspectors were satisfied that the resident continued to receive a good standard of health care. There was very good access to both general practitioners (GP) services and a range of allied health services appropriate to the residents needs. Residents confirmed that they can attend their GPs either in the surgery or in the centre. Records of these appointments and outcomes were maintained.

There was evidence of referral and consultation with allied services as required by the residents needs, including occupational therapy and mental health specialists, dentistry and opticians and neurology. Physiotherapy was available internally and residents told the inspectors how this benefited them. There was an emphasis on maintaining the resident's health and physical abilities evident and the residents confirmed this. There were evidenced based assessment tools used to determine dependency levels, nutrition and skin care needs.

Pressure areas were well managed and carefully monitored with detailed treatment plans and access to external specialist review. Specialist equipment and additional nutritional supports were seen to be available and used.

There were strategies in place to encourage healthy eating, diets and health promotion with staff and residents agreeing on food choices and weight management strategies in some instances. The residents informed the inspector of this and it was clear that staff were helping them to be informed on their overall health needs. Residents in each apartment either helped to prepare their own meals or this was undertaken for them by staff depending on their physical capacity to do so. A number of residents had specialised dietary requirements and these were seen to be adhered to. However where

residents did not wish to adhere to specific healthcare or dietary interventions this was discussed with them so that they could make informed choices.

**Judgment:**
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):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found there was a comprehensive medication management policy in place to guide practice which staff adhered to. The care staff were trained to administer medications as required where the nursing staff were not available.

While there was no resident self-medicating an assessment procedure was in place for this or it was the residents own choice not to do so. There was evidence that the pharmacist undertook reviews of medication and the medication management practices. Any errors noted were acted upon to prevent reoccurrences.

There were suitable systems in place for storage, recording, receipt of and return of all medications including controlled medications.

**Judgment:**
Compliant

**Outcome 13: Statement of Purpose**
*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The statement of purpose was revised as required to reflect the revised number of places available, the management structure and the current units which comprise the centre. Care practices and admissions were found to be congruent with the statement.

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

**Findings:**
The previous inspection found that there was no evidence of an unannounced visit to the designated centre, no written report 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 support available. Actions had been taken to address these deficits.

This inspection found that an unannounced visit had taken place in January 2016 and the report available was comprehensive with actions and timeframes identified. Additional staff had been employed for night-time to ensure there was sufficient level of support for the resident and nursing staff had been increased. At the time of the inspection a staff quarters was being erected to ensure staff could be in close proximity to the residents at night.

Some audits had been undertaken and accident and incidents were reviewed as they occurred. However the data collated was not yet analysed to identify time frames which would inform practice and development. However, from the combined information available inspectors were satisfied that the systems for monitoring the quality and safety of care were in progress and would inform a detailed annual report.

The return of the fulltime person in charge and availability of the clinical nurse manager could be seen to have a positive impact on the governance arrangements. The person in charge is fulltime in post has considerable experience and was suitably qualified. She demonstrated her knowledge of the regulations during the inspection.
There were satisfactory reporting systems evident.

**Judgment:**
Compliant

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

**Findings:**
At the time of the last inspection there was no adequate arrangement in place to provide adequate cover for the absence of the person in charge and to provide sufficient nursing support to the residents during this time. This was rectified at this inspection as the fulltime person in charge had returned to post and the clinical nurse manager 11 was nominated to cover such absences. The person is suitably qualified, the required documentation had been forwarded to the Authority and the arrangements were satisfactory.

**Judgment:**
Compliant

**Outcome 17: Workforce**
*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
At the previous inspection there were insufficient nursing staff to meet the ongoing nursing needs of the residents and to provide supervision to the care staff. The proposed staffing levels for night time also required review prior to any move from the

main building. Both of these actions were resolved. An additional nurse had been employed and additional care assistant staff had been employed to augment the night time staffing arrangement for the reconfigured units.

This resulted in four staff being available at night with one nominated to move between units as assistance was needed. It was acknowledged that there had been some difficulties in this arrangement as it was being implemented due to the change for both residents and staff. The person in charge also stated that they were considering rostering an additional staff until 11:00hours at night to support residents.

The residents were assessed as not requiring full time nursing care but they required nursing support and inspectors were satisfied that the number and availability of nurses was sufficient. A number of nursing hours support was also available at weekends. There was an on-call system in place for both management and nursing support.

An additional action was identified at this inspection. While all mandatory training had been undertaken there were deficits noted in training pertinent to the need of the residents. This included staff training in the response to incidents of choking and the use of emergency medication. It is acknowledged that no incidents of this mature had taken place but the risk was identified in some residents' care plans. This was discussed with the person in charge who agreed to remedy this immediately and did so. Confirmation that this had taken place on 11 April was received by HIQA on 12 April 2016.

There was an actual and placed roster available. Staffing was a combination of full time employees and community employment participants.

From a sample of staff files reviewed the documentation which was absent at the previous inspection had been sourced. One person recently employed did not have the required last employer reference but this was rectified during the inspection .There was a robust system in place for the employment of the community scheme personal. There was an induction programme for staff outlined to the inspector which included supernumery time but no details of this were maintained. Staff did confirm that this took place however.
A staff supervision system had been introduced in 2105 and the records indicated that this focused on the developed of skills for residents' care, respect and dignity for residents and staff training needs. A module on moving from campus to community based living had been undertaken with staff. Of the 29 staff directly employed 18 had completed FETAC level five training. Dysphagia training was scheduled for 2016.

Staff meetings were held regularly and any issues were recorded.
Staff were observed to be knowledgeable on the needs of the residents, the care practices they were implementing and respectful to the residents.

**Judgment:**
Compliant

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

**Findings:**
Residents records were found to be stored in three different locations which did not facilitate ease of access to the most up to date and relevant information to guide practice.

Documents such as the restraint assessment tool did not detail the reason why available alternatives had not been considered in the use of restraints.

Policy on recruitment did not guide safe practice.

**Judgment:**
Non Compliant - Moderate

## Closing the Visit

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

**Acknowledgements**

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

***Report Compiled by:***

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland |
| **Centre ID:** | OSV-0003437 |
| **Date of Inspection:** | 08 April 2016 |
| **Date of response:** | 25 May 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 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:**
All of the contract's seen did not detail the care and services to be provided.

**1. 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

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

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 Service Contracts for all Service Users will be reviewed and updated to include the cost of care and services to be provided.

**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:**
Systems for staff to respond and give assistance were not risk assessed in the event of a fire in the separate units.

**2. Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**
There will be a risk assessment carried out by the H&S officer to risk assess the system for notifying staff of a fire in the individual units. If this is inadequate then a new system will be implemented. The risk assessment will take place within four weeks (20th June 2016). If a new system is required this will take longer to implement - 31st August 2016 should a new system be required.

**Proposed Timescale:** 31/08/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire drills did not take account of all of units and did not reflect night-time staffing levels.

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

**Please state the actions you have taken or are planning to take:**
Complete night time evacuation has taken place (16th April 2016) since the inspection and with immediate effect they will take place four times a year.

**Proposed Timescale:** 16/04/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
To ensure that sufficient information is available to determine that there were no current safeguarding issues for residents in relation to any external persons.

**4. 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:**
Care plans to be developed around people where safeguarding issues have been identified, highlighting the additional supports that may be required to keep each person safe, particularly around visitors and persons of concern.

**Proposed Timescale:** 30/06/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Policy on the protection of vulnerable adults was not in accordance with current national requirements and policy on recruitment did not guide safe practice.

**5. Action Required:**
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

**Please state the actions you have taken or are planning to take:**
The Safeguarding Policy has been reviewed by the Safeguarding Lead and the Head of Operations. The HSE will be consulted to ensure that the policy is in accordance with current national requirements. This policy will be updated after the review as required and thereafter on the 31/01/2018.

The Policy on Recruitment guiding safe practice is being reviewed by the Service Manager and the HR Partner and the changes required will be documented and implemented to ensure compliance.

**Proposed Timescale:** 15/06/2016

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
To store residents records in a manner which facilitated ease of access to the most up to date and relevant information to guide practice and ensure records were complete.

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

**Please state the actions you have taken or are planning to take:**
We are in negotiations to acquire a staff base in one cluster house location and completing renovations in the second cluster house location. This work should be completed within three months. This will allow us to have a base location for securing records pertaining to each cluster house location.

**Proposed Timescale:** 31/08/2016