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:	Rathfredagh Cheshire Home
Centre ID:	OSV-0003449
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Patrick Quinn
Lead inspector:	Louisa Power
Support inspector(s):	Geraldine Ryan;Niall Whelton (Day 1 only)
Type of inspection	Unannounced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	7

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
18 July 2016 08:55	18 July 2016 18:00
19 July 2016 08:20	19 July 2016 17:15

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 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 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

BACKGROUND TO THE INSPECTION

This was an inspection carried out to monitor compliance with the regulations and standards and to inform a registration decision. The previous inspection was on 24/25 November 2015 and, as part of the current inspection, inspectors reviewed the actions the provider had undertaken since the previous inspection.

HOW WE GATHER OUR EVIDENCE

As part of the inspection, inspectors met and interacted with ten residents who reported that they were happy with life in the centre, their choices were promoted and staff were kind. The residents did outline that they encountered some difficulties accessing the community due to issues with transport provided by the centre. Inspectors reviewed documentation such as policies and procedures, risk assessment

and templates. Interviews were carried out with the clinical nurse and person nominated to act on behalf of the provider. Following the inspection, a formal interview with the recently appointed person in charge took place at HIQA's head office.

DESCRIPTION OF THE SERVICE
The provider must produce a document called the statement of purpose that explains the service they provide. Inspectors found that the service was being provided as it was described in that document. The centre comprised a large period two storey house and the courtyard buildings in a rural location approximately six kilometers from a large market town. The service is available to adult men and women who have primarily a physical disability or neurological condition.

OVERALL FINDINGS
Inspectors found major non-compliances in four core areas. Inadequate measures had been put in place to ensure the safety of residents who received enteral nutrition (nutrition delivered via a tube). Fire safety measures were not adequate and robust. Medicines management practices were unsafe. There were insufficient systems in place to ensure appropriate clinical governance.

The inspector was not satisfied that the provider had put system in place to ensure that the regulations were being met in a number of areas. This resulted in some positive experiences, but also poor experiences for residents, the details of which are described in the report. A number of the actions emanating from the previous inspection had not been satisfactorily completed and the proposed timescale in the provider's action plan had passed.

Good practice was identified in the following areas:
• admissions were safe (outcome 4)
• notifications were made in line with regulatory requirements (outcome 9).

The inspector found that the lack of effective governance and management systems had resulted in:
• inadequate fire safety precautions (outcome 7)
• inconsistent management of enteral nutrition (outcome 11)
• unsafe medicines management practices (outcome 12).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end. The Authority did not agree one proposed action contained in this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

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, it was not clear that a multi-disciplinary assessment had been completed and a decision had been made in the best interests of the resident where a resident was unable to express his/her views in relation to restrictive practices. On this inspection, a multi-disciplinary assessment had been completed for each resident who was unable to express his/her views in relation to restrictive practices. A clear rationale was outlined in relation to the use of restrictive practices and the decision making document demonstrated that each decision was made in the best interests of the resident.

At the previous inspection, the restrictive practices policy did not clearly protect the rights of an adult to give consent or did it outline the decision-making process in the absence of capacity. On this inspection, the policy made available to the inspectors had been reviewed in June 2016 to outline the decision making process in the absence of capacity and the policy protected the rights of an adult to give consent.

On review of residents' files, inspectors noted that a complaint received from a resident on 07 July 2016 in relation to the late administration of medicines had not been recorded in the complaints log and there was no evidence that the centre's complaints procedure had been followed in relation to this complaint. In addition, the documentation of complaints was not consistent as the staff member supporting residents to complete the required documentation did not always sign the complaints form. Furthermore, the complaints policy required review as it did not reflect the management team at the time of the inspection.

Residents with whom inspectors spoke throughout the inspection outlined that transport was not always available to them to access the community. Residents said that not all staff were trained to drive the vehicles and that when staff who were trained were on planned leave, there was a negative impact on their access to the community. Inspectors saw that a resident had made a complaint in relation to this in April 2016 and the complaints form indicated that the resident had missed a pre-arranged appointment at the opticians; the appointment had been re-arranged. This was acknowledged by the regional manager and person in charge who stated that a plan was in place to address this.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
At the previous inspection, it was found that improvements were required to ensure that all potential means of communication had been adequately explored for all residents. On this inspection, it was noted that some improvements had occurred. For a resident with specific communication needs, additional individualised supports had been put in place to support the resident's communication. However, this was dependent on the availability of staff who could provide the additional supports. When these staff members were not present, adequate measures were not in place to ensure that the resident was facilitated to communicate effectively. Staff with whom an inspector spoke reported that communication with the resident was limited when the additional individualised support staff were not present.

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

Findings:
At the previous inspection, the admissions policy did not outline the need to protect residents from abuse by their peers. On this inspection, it was noted the admissions policy had been reviewed and outlined the need to protect residents from abuse by their peers.

At the previous inspection, the written agreements did not clearly outline what the fee covered and the details of additional charges. On this inspection, a sample of written agreements was reviewed and inspectors saw that the agreements outlined what the fee covered and details of additional charges.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
At the previous inspection, the person in charge had identified a small number of residents who had expressed an interest in living in a community-based setting, in line with their assessed needs. A transition plan was not available for review in the centre during the previous inspection. On this inspection, a transition plan for decongregation 2016-2019 was made available to inspectors on the second day of the inspection. This identified that the provider had identified in 2012 that residents would require individualised services in the community, in line with their assessed needs. A profile had been prepared which outlined the name of each resident, age, years of residence, type

of disability and required housing. The required housing outlined was broad and outlined 'shared accommodation', 'individual housing' or 'apartment'. A time schedule was included which outlined that a final portfolio of moving groups and individual needs and wishes regarding housing would be completed by 19 August 2016. However, it was outlined in the report and confirmed by the person in charge that the transition plan had not been approved by senior management in the organisation and funding had yet to be secured in relation to this transition plan.

At the previous inspection, it was identified that further improvement was required in relation to the setting of goals when the personal plan was reviewed annually, particularly long term goals. The proposed timescale outlined in the provider's action plan had passed and the action had not been satisfactorily implemented. On this inspection, inspectors reviewed a sample of personal plans and saw that clear goals based on each resident's assessed needs and wishes, identified at the annual review of the personal plan, were not evident in any plans reviewed. Where goals were outlined, they were not specific and did not describe the supports required to achieve the goals to ensure that goals could be achieved in order to maximise each resident's personal development, in line with their assessed needs. The goals outlined in the personal plans reviewed were broad and included going out for meals, getting out in the community more often, joining a club, visiting home more often, meeting new people, re-engaging in activities and going to the local town independently. A proposed timeframe and person responsible was not outlined for each goal. Care staff with whom inspectors spoke could not confirm if the goals outlined had been achieved. Therefore, measures were not in place to ensure each resident's personal development.

At the previous inspection, it was not demonstrated that the review of the personal plan was multi-disciplinary. The proposed timescale outlined in the provider's action plan had passed and the action had not been satisfactorily implemented. On this inspection, inspectors reviewed a sample of personal plans and saw that a multi-disciplinary team meeting was convened for each resident on a quarterly basis but the meeting minutes did not demonstrate that the personal plan was reviewed at this meeting. Therefore, it could not be demonstrated that the review of the personal plan was multi-disciplinary.

Inspectors reviewed a sample of plans and saw that many of the plans were signed by the resident or their representatives to indicate their involvement in the personal plan. However, inspectors saw that one plan was not signed by the resident or their representative.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The centre comprised of two buildings on a large historic site. The main building consisted of a two storey period house, with a series of extensions to the side and rear. Accommodation for residents was provided on the ground floor only with the first floor consisting of staff offices, meeting rooms and sanitary facilities. Externally, the grounds were well maintained with mature trees and sufficient hard landscaping. The extensive grounds were freely accessible by residents. Residents were observed sitting out on the patio to the front throughout the inspection. To the rear of the building, there was a poly tunnel which housed plants and herbs. Adjoining this was a large concrete area with open trenches without adequate safeguarding to prevent trips or falls.

The second building (courtyard) consisted of five one-bedroom apartments, each of which opened out onto a communal courtyard. There was a large communal space with a dining area, off which a separate kitchen opened. The communal courtyard area was well maintained.

At the previous inspection, it had been identified that some parts of the centre lacked a homely feel and, as a result, residents did not use some of the social and recreational facilities. The proposed timescale outlined in the provider's action plan had passed and the action had not been satisfactorily implemented. On this inspection, it was noted that residents had been consulted in relation to décor of the social and recreational facilities. However, changes to the décor and layout of the room had not yet occurred at the time of the inspection.

At the previous inspection, there was some evidence of peeling and damaged paintwork. The proposed timescale outlined in the provider's action plan had passed and the action had not been satisfactorily implemented. On this inspection, inspectors noted areas where maintenance to the fabric of the building was required. The exit door adjacent to a bedroom required repair, in that there was a broken panel of timber on the door leaf. The automatic door located between the entrance lobby and the circulation corridor was cracked. The frames to bedroom doors were badly damaged in some areas.

At the previous inspection, it was identified that, where bedrails were fitted to beds, there was no arrangement in place to demonstrate that bedrails were checked and maintained on a regular basis. The proposed timescale outlined in the provider's action plan had passed and the action had not been satisfactorily implemented. Inspectors saw that a checklist had been introduced to prompt staff in relation to daily checks of the bedrails. However, the checklist did not demonstrate that the bedrails were examined regularly for faults, safe fitting, inappropriate gaps and structural integrity. This was discussed with senior clinical staff who stated that checks in relation to the safe structure of bedrails were not completed.

Inspectors reviewed the cleaning practices in place and spoke to staff dedicated to cleaning duties. A supervisor was appointed who was responsible for overseeing cleaning and decontamination within the centre. A cleaning schedule was in place and staff with whom inspectors spoke were aware of this schedule. However, inspectors noted many examples that indicated that a robust cleaning and decontamination process was not implemented. The floor on one bedroom was unclean. Two shower chairs were noted not to be cleaned. All window and window frames in the activity room were dusty. The cupboards and drawers in the kitchenette attached to the activity room were not clean. The toilet seat and sink in an en-suite bathroom were not clean. The exercise machines in the physiotherapy room were unclean. A hoist was noted to have last been cleaned or decontaminated on 15 March 2016. This was discussed at length with the supervisor who concurred with inspectors' findings.

Externally, improvements were required in relation to the maintenance and upkeep of the building. The fascia and soffits required cleaning and some elevations required painting. The frame surrounding openings to doors and windows were found to be not clean with cobwebs and dead insects. Windows were observed to require cleaning in general, some of which appeared to have been not cleaned for some time.

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:
Inspectors saw that the system in place to identify, assess and review clinical risk required review. A number of the residents were assessed at being at a high risk of choking or aspiration by the speech and language therapist. Risk assessments had been developed for the residents. However, inspectors noted that the risk assessments were not contemporaneous or accurate. A resident received nutrition via enteral tube to reduce the risk but this was not outlined in the risk assessment. An individualised risk assessment for the management of the risk associated with the administration of nutrition via enteral tube for this resident had not been developed. A safety alert from HIQA was issued in July 2016 due to the risk of death or injury from the appropriate management of enteral feeding.

Inspectors noted that adequate measures and actions were not in place to control risks

identified. For example, an umbrella was not provided to screen residents from the sun on the second day of the inspection and this was acknowledged by the clinical nurse manager. Where a resident kept pets, the person in charge confirmed that the risks associated with diseases that may be potentially transferred from animals to humans had not been assessed and controls were not in place.

Windows opened out at a height that may cause injury and some sliding sash windows were found to be not capable of staying up once opened. Inspectors observed signage over radiators warning that they may be hot, but some radiators were not provided with appropriate safeguarding. There was a radiator within the dedicated smoking room which was propped up with a number of blocks of timber. There were a small number of acoustically operated hold open devices fitted to fire doors, which would require a risk assessment to ensure they closed upon activation of a local fire alarm sounder. The staff entrance was fitted with two locks which require the use of a key to open the lock. There was a break glass unit adjacent to the door concerned with a key enclosed. Inspectors were told that the door was not usually locked and relied on the code access lock only to keep the door secure. Inspectors observed thresholds to some doors which could pose as a trip hazard or restriction for wheelchair users to independently manoeuvre through the door. The approach to the courtyard apartments, in front of the entrance arch was found to have manholes protruding above the finished surface of the approach route, causing a trip hazard. In the grounds to the front of the property, there was a volume of water which was not provided with appropriate guarding. To the rear of the property, there was construction work in progress consisting of an open trench for access. There was an unsecured lightweight barrier surrounding the open trench and scaffolding boards were laid down in a manner to allow circulation over the trench, which were causing a significant trip hazard. Inspectors noted that these potential hazards had not been risk assessed.

The actions with regard to fire precautions required from the previous inspection were found to be largely addressed. In addition to following up on the actions arising from the previous inspection, a specialist inspector reviewed the fire safety management practices in place, including the physical fire safety features of each building. The inspector also examined records for maintenance, fire safety training of staff, evacuation procedures and programme of drills.

The inspector noted that each building was provided with emergency lighting, firefighting equipment and a fire detection and alarm system.

There was a separate addressable fire detection and alarm system within each building, each of which was capable of identifying the location of detection on the display. There was only one fire alarm panel in the main building located remotely from the main entrance. The main building would benefit with the provision of repeater panels to enable a more efficient response to the activation of a device.

During the inspection, the inspector noted that the system in the main building displayed 'test' on the panel. A staff member contacted the fire detection and alarm system maintenance contractor who informed the staff member that this was solely to prevent the sounding of the alert to a fault from disrupting residents during the night. Later in the day, the panel displayed 'fault'. It was noted that there was no sound from

the system and staff were not aware that there was a fault with the system. This was brought to the attention of a staff member who again called the maintenance contractor. The inspector was informed that the remainder of the system was fully operational. The maintenance contractor was on site on the morning of day two of the inspection to address the fault.

There were bedrooms which had a kitchenette with cooking equipment. These rooms were provided with a heat detector only. Larger units were laid out as an apartment with a separate living area and bedroom. The bedroom in this unit type was fitted with a smoke detector and the living room provided with a heat detector. Staff informed inspectors that residents do not use the cooking equipment. Heat detectors in this instance would have been fitted to avoid false alarms, so as to allow cooking. If the cooking equipment is not being used, smoke detection within the units would provide earlier detection. This issue required review by the provider to ensure the correct level of detection is provided for the use.

Records showed that the fire detection and alarm system was being serviced at intervals varying between three and four months, but servicing did not always occur four times in a twelve month period. It was serviced within the previous three months of the date of inspection.

The inspector noted the provision of emergency lighting within the centre, but coverage was not provided as would be expected for a building of this nature. For example, the double doors from each bedroom/apartment were used for evacuation purposes and so would be considered exits. The external area, such as the external path adjacent to three bedrooms was not sufficiently provided with emergency lighting coverage. The inspectors saw documentation recommending upgrading works to the emergency lighting system, some of which had been carried out. It is noted that bedrooms were not provided with emergency lighting coverage, however inspectors noted that this was one of the recommendations from the emergency lighting contractor in 2014. The records available to the inspector on the day of inspection indicated that the emergency lighting system was being serviced at intervals ranging from six months to eleven months and not quarterly.

The provider had made arrangements for fire safety training to be provided to staff. However, documentation available to inspectors indicated that all staff had not received training within the previous 12 months, with 25 staff members having not received training within the previous 24 months and 10 staff members with no training provided.

Fire drill records were available indicating that fire drills were being carried out in the centre. At the previous inspection, inspectors found that although regular drills were being carried out, the duration of the drills were excessive and required improvement. At this inspection, it was noted that the times for evacuation were improved and reduced to an acceptable level. The records contained details of issues encountered during the drill, and any actions required. However, further improvement was required in the detail recorded for the drills. For example, in some instances, the times entered for the drill reflected the time occupants returned to the building and not the time the drill ended.

There was a fire procedure in place in the building. This was displayed in both written and drawing format. The drawings displayed around the building were rudimentary in nature and did not adequately portray the evacuation routes and exits. Furthermore, following review of documentation and discussions with staff, it was not clear to the inspector as to which type of evacuation takes place at the centre, i.e. progressive horizontal evacuation where residents are evacuated on a phased basis or if the centre was totally evacuated in the event of an emergency.

Inspectors found that the needs of residents in the event of a fire were assessed by way of a 'Personal Emergency Egress Plan' (PEEP). At the last inspection, inspectors found that the PEEPs required improvement. At this inspection, they were found to be detailed and addressed the methods of evacuation for both day and night time scenarios.

In general, the inspector found that each building was laid out such that residents and other occupants were provided with an appropriate number of escape routes and fire exits. In the main, bedrooms and apartments were provided with double doors leading directly to open air. Bedrooms and apartments were found to have either an electronic magnetic locking device or thumb turn manual door opening fastenings. Although the evacuation procedure was not clear, it appeared that methods of evacuation included accessing resident's rooms from the outside, requiring a key in some instances. Throughout the centre, bed evacuation was available which would include moving beds to an assembly point. The external path outside two bedrooms was laid out such that the path widened at each exit to allow for beds to be moved out of the room and directed along the path. The planting in these widened areas were encroaching on the usable space and required clearing.

On the first day of inspection, the inspector noted that there were three final exits which were locked with a shooting bolt at a high level. The door was also fitted with a push bar type panic bolt which was not capable of opening the door if the shooting bolt was engaged. The three exits included one from the dining area and the final exits adjacent to two bedrooms. The inspector brought this to the attention of a staff member, who arranged for the shooting bolts to be removed. Although the records kept for the regular checks of exits indicated that they were being checked daily, the inspector found that the exit located near the ground floor staff room, required excessive force to open it.

In general, the inspector found that the centre was subdivided with construction which would resist the passage of fire and smoke in most cases. Fire doors in general were furnished with the appropriate features comprising a fire rated door set. It was noted that an audit of fire doors, throughout the centre would be required to identify any deficiencies of the fire door assemblies. There were doors with large gaps, warped door leafs, non-functioning self-closing devices, damaged door leafs and missing or damaged cold smoke seals and intumescent strips. The inspector found that the door to the prayer room was held in the open position with a chain. In addition, the store adjacent to the laundry and the door to the office adjacent to the reception did not have a self closing devices fitted to them and were found to be in the open position. Both doors to the dining area required repair, one of which had a large gap between the doors and the other was found to be hanging off the hinge.

The kitchen was not enclosed in construction capable of containing a fire. The fire door

from the kitchen to a lobby area was fitted with a vent, thereby rendering the fire door ineffective. There was also a mechanical fan in the wall above this door. In addition, there was a roller shutter door above the server counter, which appeared to be a fire rated door. The counter below the roller shutter door had cutlery trays and a toaster which would prevent the door from closing in the event of a fire. There was a fire risk assessment report issued in October 2015, identifying the need for an extinguishing suppression system to be fitted over the deep fat fryer. The timeline recommended for the suppression system to be installed was February 2016. A staff member in the kitchen stated that the deep fat fryer was not in use until such time as the suppression system was installed. Outside the kitchen exit, the gas shut off valve was obstructed by a number of wheelie bins.

Inspectors found the prayer room to be provided with a fabric lining to the vaulted ceiling. The inspector was not assured that the fabric was appropriately treated to reduce the spread of fire.

There were gaps and imperfections of fit within the enclosure to some rooms, which would be required to be enclosed in construction resisting the passage of fire. The areas noted included the motor room associated with the lift and the room containing the gas boiler.

Some residents smoked and a dedicated smoking area was located internally in the main building. In the courtyard building, there were two residents who smoked, one of whom smoked in their apartment. The inspector saw a risk assessment for this resident. The other resident in the courtyard building smokes outside only.

Inspectors noted control measures were in place in the dedicated smoking area. These included a log of frequent checks and metal ash trays, which were emptied on a regular basis. There were smoking aprons also available for use. A fire extinguisher was available in the smoking room, however a fire blanket was not provided. The inspector could not determine that the upholstered furniture and the drapes were not flammable. One armchair was found to have a tear on the seat, thus exposing the filling material. Similarly, the drapes fitted over the window did not contain a label confirming they were not flammable.

Some residents were permitted to smoke in their bedroom. The risk assessment for one resident stated that the resident should smoke in the dedicated smoking area only, and that staff are to light and extinguish the cigarette for them. The risk assessment indicated that the resident's lighter should be kept out of reach. On three occasions during the inspection, inspectors observed the same resident smoking unsupervised with access to lighter and cigarettes in the residents own room. There were scorch marks on the floor covering where the resident smoked, adjacent to the external access door.

Regular fire safety checks were carried out for the fire safety systems in the centre. While this was good practice, the checks were not of adequate extent or detail to ensure all fire safety features were functioning correctly. The aforementioned findings relating to damaged or non functioning fire doors and the damaged upholstered furniture in the smoking room indicated that the system of fire safety checks required review to ensure they were of adequate extent, frequency and detail. The inspector spoke with staff and

found them to be knowledgeable as to what constituted good fire safety practice.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
At the previous inspection, it had been identified that not all staff had received training in relation to the management of behaviours that challenge. The proposed timescale outlined in the provider's action plan had passed and the action had not been satisfactorily implemented. On the second day of the inspection, an updated training matrix was made available to inspectors which indicated that six staff members who provided direct support to residents had not received training in relation to the management of behaviours that challenge as required by the regulations.

At the previous inspection, it was not demonstrated that the use of restrictive practices such a bedrails or lapbelts were monitored. The proposed timescale outlined in the provider's action plan had passed and the action had not been satisfactorily implemented. On this inspection, inspectors saw that a daily check list had been introduced which included recorded if a restrictive practice was in place. However, the check list did not indicate that the restrictive practice was checked regularly to prevent entrapment or injury. In addition, the check list did not indicate that opportunities for motion/exercise were afforded to the resident by means of a 'release' of the restrictive practice.

An inspector reviewed a sample of behaviour support plans and found that they demonstrated a positive approach to behaviour that may challenge. The behaviour support plan included possible causes, triggers, warning signs, proactive strategies, reactive strategies and debriefing following an incident. The person in charge and other staff articulated how they support residents in a positive way to manage their own behaviours. Behaviour supports were reviewed by the multi-disciplinary team. However, for a resident who was prescribed an 'as required' psychotropic medicine, the behaviour

support plan did not contain information to guide staff in relation to appropriate administration of this medicine. Staff with whom the inspector spoke outlined that the medicine was administered for symptoms that differed from those identified by the prescriber on the current prescription.

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:
At the previous inspection, inspectors found that relevant incidents had not been notified to the Chief Inspector in line with regulatory requirements. On this inspection, it was noted that a comprehensive record of all incidents was maintained. Notifications were made in line with the requirements of the regulations.

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

Findings:
At the previous inspection, the assessment process in place to establish and realise each resident's education/training/employment goals was not clear. The proposed timescale outlined in the provider's action plan had passed and the action had not been

satisfactorily implemented. On this inspection, inspectors reviewed a sample of personal plans and saw that domains in relation to literacy, household supports and money management were included. The domain in relation to literacy outlined if the resident was receiving support in relation to this domain and educational opportunities, if required. The domain in relation to household supports outlined if the resident required support in relation to life skills for household tasks. The domain in relation to money management outlined if the resident required support in relation to financial management or had a money management plan in place. However, clear goals did not emanate from these domains to ensure the resident's personal development and to promote life skills. In addition, clear goals in relation to education/training/employment were not evident on the personal plans reviewed. Therefore, it could not be demonstrated that residents were supported to access opportunities for education, training and employment that were in line with their assessed needs and wishes.

At the previous inspection, the policy on access to education, training and development did not outline the arrangements in place to ensure that residents were supported to access opportunities for education, training and employment and that continuity was maintained in relation to this when residents were in transition. The proposed timescale outlined in the provider's action plan had passed and the action had not been satisfactorily implemented. The policy on access to education, training and development made available to inspectors on this inspection had not been reviewed.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
At the previous inspection, a judgment of moderate non-compliance was made in relation to healthcare needs. On this inspection, due to the potential catastrophic risks for residents associated with the non-compliances identified, inspectors deemed this to be at a level of major non compliance.

The clinical nurse manager informed inspectors that one resident received nutrition via enteral tube. Inspectors were not satisfied that robust measures were in place to manage the risk associated. Inspectors saw and staff confirmed that the resident received nutrition as a continuous infusion during the day. Appropriate and regular input

had been sought from the dietician. The care plan outlined a number of controls that were in place to manage the risks associated with enteral nutrition including hourly checks, monitoring of fluid intake/output, regular flushes of the equipment and cleaning of the entry site. However, these controls were not implemented. Staff confirmed that the checks did not occur hourly as outlined in the care plan. The fluid intake/output chart was not consistently maintained and was unclear in relation to the total volume of nutrition infused, the rate of infusion, volume introduced during flushes, total fluid remaining, oral intake and output. Staff were unable to explain the implementation of the fluid intake/output chart and inspectors saw that recording was sporadic and incomplete on all charts reviewed. It could not be demonstrated, due to inaccurate and conflicting documentation, that the resident received the required daily fluid intake to meet individual requirements in line with the dietician's recommendations. The information in the care plan in relation to flushes was not consistent with the recommendations made by the dietician. The care plan did not outline specific guidance in relation to the cleaning of the entry site. Staff reported that the entry site was observed and cleaned daily but documentary evidence was not available to support this. Therefore, inspectors concluded that inadequate measures had been put in place to ensure the safety of residents who received enteral nutrition.

At the previous inspection, it had been identified that the system in place to develop and review care plans in line with each resident's assessed needs was inadequate. The proposed timescale in the action plan submitted by the provider had passed and the action had not been satisfactorily implemented. Inspectors noted that the recommendations from specialist speech and language therapists to prevent harm as a result of choking or aspiration were not incorporated into two resident's care plans reviewed during the inspection. Where evidence based assessment tools were used to assess individual clinical risk, this was not incorporated into care plans.

Some residents required regular and 'as required' pain relief and care plans had been developed to guide staff to support residents to manage pain. However, inspectors saw that care plans were not followed. Care plans outlined that pain was to be re-assessed after 20-30 minutes following the administration of pain relief to ensure that the medicine was effective. However, inspectors saw that, for one resident who had required six administrations of 'as required' pain relief since 09 May 2016, pain had not been re-assessed as outlined in the care plan on any occasion. Staff with whom inspectors spoke were unable to confirm that pain had been re-assessed formally as outlined in the care plan.

Where residents required referral for specialist input, inspectors saw that some referrals were not consistently and appropriately followed up. One resident had been referred to a urology consultant but the resident's care plan did not list a person responsible to follow up on this referral, in line with the centre's policies and procedures, to ensure that the resident received timely access to healthcare. Another resident required an optical review and a letter had been received on 13 July 2016 in relation to eligibility but this had not been followed up on.

Inspectors saw that care plans were not updated when residents' healthcare needs changed. It was noted that a care plan in relation to catheterisation had not been updated when the size of the catheter to be inserted had changed. The resident's

catheter was changed by the urology team in the hospital every eight weeks and the change had been made on 19 February 2016.

Judgment:
Non Compliant - Major

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
This outcome was reviewed by a medicines management inspector. A notification had been made to the Chief Inspector that a medicines related incident had occurred in June 2016 where a resident had been inadvertently administered a second dose of an anti-coagulant ('blood thining') medicine. This had led to the resident being transferred to hospital for investigations. The inspector concluded that there were unsafe medicines management practices within the centre.

At the previous inspection, it had been identified that the balance of medicines with additional controls was not checked at the handover of the afternoon shift to maintain a robust chain of custody. On this inspection, the inspector saw that the balance of medicines with additional controls was checked at the handover of each afternoon shift to maintain a robust chain of custody. However, the inspector saw that a medicine requiring additional controls was recorded as being removed from safe custody on two occasions since 01 June 2016 an hour before the medicine was recorded as administered to the resident. Therefore, the safe custody and control of this medicine could not be demonstrated at all times.

At the previous inspection, it had been identified that medicines were not administered as prescribed. On this inspection, the inspector saw numerous examples where medicines were not administered as prescribed and, due to the potentially catastrophic nature of medication related incidents, the inspector deemed this to be at a level of major non compliance.

Medicines were not always administered at the times prescribed. The inspector saw that two medicines for pain relief were administered four and two hours later than the times prescribed on a consistent basis for the month preceding the inspection.

A resident required all medicines to be crushed and administered via an enteral tube. Of

the seventeen medicines administered via the enteral tube, two medicines were prescribed to be administered orally and did not specify that the medicine had to be crushed prior to administration.

A resident was prescribed a preparation for dry eye. The medicine administered did not contain the same active ingredient and there was no record that clarification had been sought from the prescriber.

The inspector noted that a number of verbal orders had been received by nursing staff within the centre. The verbal orders related to 'blood thinning' medicines which can have potentially major/catastrophic impact if administered at the incorrect dose. The practice for the receipt of verbal orders within the centre was not safe. Verbal orders did record the time of the receipt of the order, the prescriber's full name and her/his confirmation of the order. The justification and rationale for accepting a verbal or telephone medication order was not documented in line with professional guidance. It was not recorded that the medical practitioner repeated the order to a second staff member.

Prescription records were transcribed and a sample was reviewed by the inspector. Transcribed records contained the date of prescription, medicine, dose, indication, route and time to be administered. However, all transcribed records reviewed were not complete and inaccuracies/errors were noted. The date of transcription and the date of the prescriber's signature were not recorded. Two transcribed records reviewed did not contain the signature of the person independently checking the transcribed record. The transcribed record for a cardiac medicine recorded the dose as 62.5mg which was 1000 times the dose actually administered. Spelling errors were noted on all transcribed records seen during the inspection.

Staff within the centre reported that a resident was self administering inhaled medicines to promote independence. However, the inspector saw and staff confirmed that an appropriate risk assessment had not been completed to guide this practice and inadequate oversight was in place to ensure compliance and concordance with the prescribed medicines.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
At the previous inspection, it was identified that the statement of purpose did not contain much of the information set out in Schedule 1. On this inspection, the statement of purpose made available to inspectors had been reviewed to contain all information set out in Schedule 1.

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:
At the previous inspection, it was identified that an annual review of the quality and safety of care and support in the centre had not been completed. On this inspection, the regional manager made the service review, dated December 2015, was made available to inspectors. The service review examined areas such as staffing levels, service delivery, personal goals, community inclusion, complaints management, incidents and audit findings. Individual meetings were held with residents which informed the review. However, the regional manager acknowledged that improvement was required to ensure that the annual review covered all aspects of care and support in the centre to ensure a quality and safe service was provided. An action plan did not emanate from the annual review to demonstrate learning and continual improvement.

There had been a change of person in charge since the last inspection. The person in charge was interviewed following the inspection. The person in charge had commenced in her role on 18 April 2016. The person in charge demonstrated that she had the appropriate qualifications, skills and experience to manage the designated centre. The person in charge confirmed that she had many years' experience supporting people with disabilities. The person in charge had worked in a management or supervisory role in the area of social care for over three years. The person in charge held an appropriate qualification in social care management.

Inspectors noted that residents had complex conditions and required significant clinical support. These complex conditions included multiple sclerosis, acquired brain injury, epilepsy, history of stroke, diabetes, visual impairment and muscular dystrophy. The residents required a number of clinical interventions on a daily basis including the management of catheters, enteral tubes, assistance with dining, pain management and complex medicines management. Major non compliances were identified in relation to health care needs due to a lack of a consistent approach to supporting residents in this area. Potentially unsafe practices were observed in relation to the management of the enteral nutrition. Inspectors saw and the provider agreed that there was inadequate oversight in relation to the important daily clinical interventions to ensure resident safety. Based on the findings of the report, inspectors concluded that there was inadequate clinical governance in the centre which placed residents at risk of a potentially catastrophic outcome.

There was also evidence of inadequate overall governance and management as detailed throughout this inspection report. A total of 20 actions emanating from previous inspections had not been satisfactorily implemented, especially in relation to the provision of mandatory staff training. Complaints were not documented and investigated in line with the centre's policy and procedure. There was a lack of suitable staff to provide the additional supports and transport for residents who wished the access the community. The provider had not adequately progressed the transition plan, even though the need for residents to transition to the community had been identified in 2012. There were inadequate arrangements in relation to fire safety and risk management. Unsafe medicines management practices were observed.

Judgment:
Non Compliant - Major

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:
At the previous inspection, gaps were noted in training in relation to epilepsy and catheter care for non-nursing staff. An updated training matrix was made available to inspectors on the second day of the inspection which indicated that training in relation

to epilepsy and catheter care had been completed by non-nursing staff.

However, the training matrix did indicate gaps in training that would be required in line with residents' assessed needs. The updated training matrix indicated that five staff who provided direct resident care had not completed dysphagia training to support residents who were at risk of choking or required modified food or fluids.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
At the previous inspection, it had been identified that incomplete medication administration records were maintained. Some improvement had been noted in relation to this. All medication administration records reviewed recorded the time of administration. Where a dose range was prescribed, the actual dose administered was recorded on the medication administration record. However, for one medicine on one medication administration record reviewed, the record was left blank with no reason recorded on six occasions since 04 July 2016.

At the previous inspection, it was identified that the policy in relation to food and nutrition required review as it did not outline the monitoring and documentation of nutritional intake. On this inspection, inspectors saw that the policy had been reviewed.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Louisa Power
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003449
Date of Inspection:	18 and 19 July 2016
Date of response:	07 November 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:
Transport was not always available to residents in order to access the community.

1. Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

Please state the actions you have taken or are planning to take:
A new van to be purchased that is better suitable for the staff to drive, finalized 09/09/2016

Additional external transportation company sourced to support when needed, finalized in July 2016

All staff eligible to get driving lessons from the driver to be able to use the busses. 30/10/2016

An additional bus driver to be trained to drive the big D-licence van, driver to be fully trained in next 6months which is the minimum to acquire the licence, finished by 31/12/2016

Proposed Timescale: 31/12/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Practice around the management of complaints is inconsistent.

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

Please state the actions you have taken or are planning to take:
The specific concern in respect of a complaint by a resident brought to the attention of the provider has been addressed and resolved as and is available for inspection. In addition, a robust system for medication governance is been put into place, whereby medication documentation will be weekly spot check audited by management of the service starting from 19/09/2016

All existing complaints from residents on record have been reviewed with the resident in question and signed by the relevant staff member. The complaints policy now specifies that the signature of the assisting staff member must be on the complaints form. All staff will have been advised of this and all staff will have signed the revised complaints policy to this effect by 30/09/2016

Proposed Timescale: 30/09/2016

Proposed Timescale: 30/09/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy required review as it did not reflect the management team at the time of the inspection.

3. Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

Please state the actions you have taken or are planning to take:
The policy has been updated to reflect the current management team and that it will be kept under review by the nominated provider if there are any managerial changes finalized 12/09/2016.

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate measures were not in place to ensure that a resident was facilitated to communicate effectively at all times

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

Please state the actions you have taken or are planning to take:
Holistic communication plan including staff responsibility to learn everyday language of polish so they can understand the resident in question.

AAC methods were trialled in July 2016 but the particular resident identified on inspection was not very keen on using assistive devices or methods to communicate, so a new plan is under trial around the resident's communication needs and the methods for staff to support him around this. Where needed additional pictures will be used if/ when needing to i.e. measure pain. This will be kept under review.

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The transition plan had not been approved by senior management in the organisation and funding had yet to be secured in relation to this transition plan.

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

Please state the actions you have taken or are planning to take:
The transition plan for the Limerick Service has been put on hold until NABCO the Housing Company in question has acquired the housing in the Caherconlish area of Limerick. The Transition plan will be signed off as required once the suitable housing is sourced.

The Provider Nominee will inform HIQA when the Housing is acquired and the transition plan is approved. Update to HIQA will be provided on 31/12/2016 or earlier if there are developments.

Proposed Timescale: 31/12/2016

Proposed Timescale: 31/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A proposed timeframe and person responsible was not outlined for each goal.

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

Please state the actions you have taken or are planning to take:
A new personal plan format has been put in place. The personal plans will have goals, timelines, and a person responsible to support the resident to meet these goals. All goals will be set using the principle of SMART.

Each plan will state what the frequency of review is and who the person responsible for

reviewing the plan is and additionally what actions are carried out daily/ weekly and who is responsible for carrying out each action.

All plans will be set in the new format by end of October and reviewed with the residents giving them the choice to set their own goals and timelines for them and what support would they most benefit from. Finalized by 30/10/2016

Proposed Timescale: 30/10/2016

Proposed Timescale: 30/10/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Clear goals based on each resident's assessed needs and wishes were not evident in any plans reviewed to ensure each resident's personal development.

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 goal based functional personal plan system is being developed and will be in place by 30/10/2016.

Each plan will be set with the resident around their goals; these are divided into sections including: Physical skills, OT, Vocational and work, Academic, Adaptive/ life skills and Hobbies/personal interests/ personal development.

Each person will have a set of goals that focused on the wishes of the individual and set through the principles of SMART and they will be assessed on given timeline for each goal to develop.

As part of this process of personal planning the staff will support the residents go improve their ability to set their own personal goals and support them to achieve these goals.

Proposed Timescale: 30/10/2016

Proposed Timescale: 30/10/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It could not be demonstrated that the review of the personal plan was multi-disciplinary.

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

Please state the actions you have taken or are planning to take:
Each individuals personal plan will be reviewed in the MTD meetings
MDT minutes outcomes will be reflected in each resident's personal plan and included in their ongoing activities. PPs' will be updated now based on the previous MTD meetings and reviewed with residents by end of October 2016.

MDT meetings will review personal plans and sections outlined as therapist responsibilities, MTD meetings will be held quarterly. Depending on the residents support requirements each required professional will be invited as needed.
The outcomes of the MTD meetings will be reflected in the personal plans. Finalized by 30/10/2016

Proposed Timescale: 30/10/2016

Proposed Timescale: 30/10/2016
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One personal plan was not signed by the resident or their representatives to indicate their involvement in the personal plan.

9. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
All personal plans have been reviewed to ensure the participation of the resident is documented.

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some parts of the centre lacked a homely feel and, as a result, residents did not use some of the social and recreational facilities.

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:
The living room has been painted, new curtains have been installed, new sofas supplied and décor updated and TV installed for residents.

A varied collection of books (including audio devices) have been added to room. Residents can entertain family or friends in the living room and the catering team will support them to provide refreshments if they choose to do so.

Movie nights take place in the living room, each movie night is advertised on the resident notice board to make the residents aware of the film and when it is on.

All finalized 20/09/2016

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was some evidence of scuffed, chipped and damaged paintwork.

The exit door adjacent to room G6, which had a broken timber panel required repair.

The glass to the automatic door between the entrance lobby and the corridor required repair.

Externally, the fascia and soffits required cleaning and some elevations required painting.

The frame surrounding openings to doors and windows required cleaning.

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

Please state the actions you have taken or are planning to take:
Building has been divided to 4 sectors that have been painted and any structural minor damages fixed and identified on annual maintenance plan to meet these needs.
Any damages causing hazard will be fixed on immediate basis. Staffs are required to report any issues in the maintenance log book that is checked daily by maintenance all repairs are recorded.

The door in question in the main report has been fixed in September 2016. The frames of the bedrooms outlined in the report will be fixed by 31/12/2016

A new glass for the automatic door is being measured on 23/09/2016

An external cleaning contractor has been employed to clean the windows internally and externally. They will do the internally bi monthly and external bi monthly. The curtains cleaned in July 2016 and they will be cleaned as required in the future, at least annually. All minor repairs have been added to the annual maintenance plan; any cleaning issues have been added to the roster for the housekeeping team. There is a log of cleaning data in the housekeepers files and this is audited by housekeeping manager monthly.

The respite rooms referenced in the inspection report have been fixed and future cleaning of the respites is added to the cleaning roster. Other areas in the report such as the bathroom and toilet area have been completed as required.

Proposed Timescale: 31/12/2016

Proposed Timescale: 31/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where bedrails were fitted to beds, there was no arrangement in place to demonstrate that bedrails were checked and maintained on a regular basis.

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

Please state the actions you have taken or are planning to take:
Bedrails and all enablers/restrains structural integrity monitoring are added a monthly

rota to be done by Therapy facilitator. He will check the rails and their condition monthly, should there be any changes or damages an external company will be contacted for servicing 22/09/2016.

Hoists, wheelchairs and physioroom added to annual housekeeping/ minor repairs rota and will be monitored by therapies facilitator as well the overall condition of all therapy materials/ equipment.

Equipment stored in room G20 such as the shower bed fixed with duct tape, has been replaced 22/07/2016

All therapy equipment added to therapy facilitator checklist in the overall housekeeping/ minor repairs file to be checked monthly, file finalized 20/09/2016
Physio equipment checked annually by company OPM. Ongoing

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A robust cleaning and decontamination process was not implemented.

13. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
All issues outlined in the main body of the report such as window cleaning, rust in toilet, curtains , staff toilet, visitor room and cupboard in the kitchen and activity room, cleaning of hoists and physio room have all been rectified as of 20/09/2016

To avoid future reoccurrence in a drop of hygiene standards the cleaning roster has been reviewed and edited and a member of senior team will audit the standards monthly and make recommendations as required. These recommendations will be added to service action plan.

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

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:
Adequate measures and actions were not in place to control risks identified.

The system in place to identify, assess and review clinical risk required review

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

Please state the actions you have taken or are planning to take:
An individualised risk assessment for the management of the risk associated with the administration of nutrition via enteral tube revised has now been updated to reflect the changing needs. The CNM will review this monthly.

In the future regarding the weather, sufficient safeguarding material will be provided to all residents, this has been discussed in advocacy meetings in August as part of the safeguarding section finalized 30/08/2016

Residents' animals have been assigned to specialist tests in Wicklow veterinary hospital specialized to exotic birds. As per advised Spittacosis blood test has been completed to both and copy of test filed accordingly. Finalized 30/07/2016

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to risk management as not all risks were adequately addressed.

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

Please state the actions you have taken or are planning to take:
All identified risks have been assessed and actions have been put on place to reduce the risk such as :
• Stoppers to be installed to the windows. Finalized by 30/09/2016
• All radiators in public spaces have thermostatic valves that can be adjusted if hot. The temperature was monitored and none of them was getting dangerously hot. Finalized 20/09/2016

• Blocks under radiator have been removed and radiator has been fixed up to standard. Finalized 30/08/2016
• Self-closing devices have been added to the doors of the store adjacent to the laundry and the door to the office adjacent to the reception. Finalized by 20/09/2016
• Prayer room door chain has been taken out and magnetic system installed 22/07/2016
• Bolts removed from all doors mentioned by inspectors in July 2016 Finalized 22/07/2016
• Where cooking equipment is not being used stoves have been disconnect but not removed (in case resident wants to use it later), when a stove is in use in an apartment additional smoke detectors will be supplied as required. Finalized 30/08/2016
• The construction at the back of the kitchen area was finalized in end of July 2016.
• In future external contractors will be asked for assurance that adequate safeguarding in on place Finalized 15/08/2016
• The pond has been fenced safely and warning signs added. Finalized 15/08/2016
• The whole manhole cover has been raised to ground level to ensure it does not cause a trip hazard. A no parking sign has been added to stop drivers accessing the area which can cause the manhole cover to crack, please see pictures attached. Additional risk assessment has been carried out to evaluate the possible. Work completed on the 22.09.2016.'
• An expert consultant is currently conducting a review of solutions for similar doors utilized in various large hospitals and will come back to us by the 31/10/2016 with workable solutions. Any recommended works will be arranged and undertaken as a matter of urgency
• Risk assessment concerning a resident smoking inside has been carefully reviewed and re-written by CNMII and the resident has now agreed to use an electronic cigarette which been purchased. Finalized 20/09/2016
• In relation to the gas shutoff valve all obstructions such as Outside the kitchen exit, Wheelie bins have been relocated
• Housekeeping and maintenance staff instructed as not to displace them again. Finalized 22/07/2016
• All planting possible obstructing external evacuation routes have been removed.
• External areas added to annual housekeeping and maintenance plan. Finalized 22/09/2016
• During night time fire drills carried out it was noted that the thresholds of doors not impede the evacuation of the residents beds. An expert consultant is currently conducting a review of solutions for similar doors utilized in various large hospitals and will come back to us by the 31/10/2016 with workable solutions. Any recommended works will be arranged and undertaken as a matter of urgency

Proposed Timescale: 30/09/2016

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

The inspector was not assured that upholstered furniture was not flammable.

There was an armchair in the smoking room which was found to have a tear on the seat, thus exposing the filling material.

The drapes fitted over the window within the smoking room did not contain a label confirming they were not flammable.

The inspector was not assured that the fabric lining to the ceiling of the Prayer Room was appropriately treated to reduce the spread of fire.

16. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
• Fire blanket purchased to be available for people using the smoking room and staff if needed. Finalized 20/09/2016

• As mentioned in the main body of the report the arm chairs and curtains have been removed from designated smoking area. The living room area has been upgraded to be used as communal area to encourage residents to rather use this rather than the smoking area for socializing. Finalized 15/09/2016

• The material in the prayer room has now been removed. Finalized 20/07/2016

Proposed Timescale: Complete 7.11.16

Proposed Timescale: 07/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire safety maintenance arrangements in place were not adequate in the following respects:

A number of fire resistant doors were not maintained in a manner that would ensure they would perform effectively in the event of a fire.

The emergency lighting was not inspected on a quarterly basis in a manner prescribed in the relevant technical standard.

The system of in house fire safety checks required review to ensure they were carried out in adequate detail.

Planting was encroaching on some defined external escape routes.

17. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
A specialist fire consultant visited the premises on 22/09/2016. As per the of the consultant recommendation, smoke detectors were agreed as the most suitable early protection with regard to fire in this situation. Quotes were sought. The works are underway and will be finalized by 30/10/2016

All cooking equipment in the apartments is disconnected. This work was completed on 30/07/2016.

The drill template has been updated with the advice and assistance of the National Health, Safety and Risk Manager of Cheshire Ireland to reflect the duration of the drill. The evacuation plans have been updated and the information was also added to the fire board clarifying that the centre follows phased evacuation protocol. This is now also highlighted in the Fire Warden training. The Drill template was updated on the 22/07/2016. All other information was updated 22/09/2016

Evacuation protocol has been updated to highlight clearly that in the service the main evacuation method is phased evacuation. Updated on 20/07/2016

Quotes were sought to install new locks for all the residents' back doors that have individual keys and a master key for evacuation. New locks will be installed by 31/10/2016

Vent in kitchen has been filled and fan to remove as instructed. Finalized on 22/09/2016

Fan in kitchen has been removed as per fire safety advice from inspector Finalized on 22/09/2016

Dining room area door have been assessed, internal measures have been put in place and further works will take place as outlined by fire consultant report 30/09/2016

All materials obstructing the shutter in the kitchen area have been removed. Finalized 20/07/2016

Deep fat fryer taken out, grease fire risk eliminated. Finalized 22/07/2016

Gaps have been filled with fire proof material in the motor room associated with the lift and the room containing the gas boiler. Finalized 20/09/2016

Test voice activated doors and automatic fire doors and sign them accordingly in the drills template, awaiting clarification from fire consultant 30/10/2016, was on site on

17/09/2016

The planting in these widened areas has been removed 19/07/2016
External areas added to annual housekeeping and maintenance metafile. Finalized 22/09/2016

Self-closing devices has been added to the doors of the store adjacent to the laundry and the door to the office adjacent to the reception, finalised 19/09/2016

The fire doors had been reviewed by a consultant in 2015. The consultant conducted an extra inspection to review the previous report on the 15/09/2016 and identified works have been carried out satisfactorily (seals replaced, doors reconnected, gaps fixed). Missing items were completed on the 22/09/2016. The dining room door was assessed and requires a new frame. This arrived on 12/10/2016 and will be fitted on 17/10/2016.

All staff carrying out fire checks (weekly and daily) will be retrained in the detail of the fire checks procedure by the in house fire and safety representative on 26.10.2016 and 28.10.2016. The checks will be audited monthly by the in house Health and Safety representative and overseen by the PIC. Any concerns will be brought to the attention of the Health and Safety Representative and escalated to the Regional Manager and the National Health, Safety and Risk Manager as appropriate

The Emergency lighting system was last inspected on 20.4.2016 and 15.8.2016. The next inspections are scheduled for 17.10.2016 and 16.1.2017

Proposed Timescale: 30/11/2016

Proposed Timescale: 30/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some external escape routes were not adequately provided with emergency lighting coverage.

18. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
Advice sought from specialized company to provide instructions for external emergency lighting coverage as per safety regulations. Will be completed by 30/11/2016

Proposed Timescale: 30/11/2016

Proposed Timescale: 30/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The kitchen was not enclosed in construction capable of containing a fire.

The fire rated enclosure to some rooms was not imperforate and contained holes or gaps breaching the line of fire resistance.

19. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
The vent and the fan in the kitchen door have been filled and fan to remove as instructed. Finalized 22/09/2016

Both doors to the dining have been assessed and interim measures have been put in place until the doors and the frame can be to be changed this will be completed by the maintenance team by the 30/10/2016

All materials obstructing the shutter in the kitchen area have been removed. Finalized 20/07/2016

Deep fat fryer in the main kitchen has been taken out, grease fire risk eliminated. Finalized 22/07/2016

Gaps have been filled with fire proof material in the motor room associated with the lift and the room containing the gas boiler. Finalized 20/09/2016

Courtyard kitchen doors fixed 20/07/2016

All notified cold smoke seals have been re-installed; doors with gaps have been looked at and installed with seals or fixed by 30/10/2016

Shooting bolts removed from all doors that were identified by inspectors. Finalized 22/07/2016

Proposed Timescale: 30/10/2016

Proposed Timescale: 30/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire safety training had not been provided to any staff members within the previous twelve months from the date of inspection.

20. 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 fire safety training required was completed on the 21/09/2016 including all new staff (one missing that will do a training returning from holidays in beginning of October 2016)

Local training matrix will be kept for the purpose of cross checking numbers of staff needing training and refresher courses. Finalized 15/09/2016

Proposed Timescale: 10/10/2016

Proposed Timescale: 10/10/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The drawings displayed around the centre did not adequately identify the evacuation routes and exits.

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

Please state the actions you have taken or are planning to take:
Drawings have been updated (by templates) around building to provide better picture of the evacuation routes around the building. Visitor maps of both levels have been added to lobby to show main areas of building, Finalized 15/09/2016

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Six staff members who provided direct support to residents had not received training in relation to the management of behaviours that challenge, as required by the regulations.

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

Please state the actions you have taken or are planning to take:
All remaining staff to be trained in positive behaviour support by regional quality representative. All remaining staff training will be completed on 29/09/2016

Proposed Timescale: 29/09/2016

Proposed Timescale: 29/09/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that the use of restrictive practices such a bedrails or lapbelts were monitored.

It was not demonstrated that opportunities for motion/exercise were afforded to the resident by means of a 'release' of the restrictive practice.

The behaviour support plan did not contain information to guide staff in relation to appropriate administration of an 'as required' psychotropic medicine for one resident.

23. 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:
The restraints checklist has been updated to reflect the removal of the restraint on a regular basis as required and will be added to all residents plans where needed.

Restraints and enablers have been added to personal plans that highlight the intervals the residents need ‘release’ of restrictive practices and how this is to be monitored, all plans to be updated by 20/09/2016.

The overall need for restrictive practices will be reviewed quarterly through the MTD review process.

Any 'as required' psychotropic medicine will be reviewed quarterly or as required by the CNMII and any changes will be reflected in the residents personal plan, Finalized 22/09/2016

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

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

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

24. 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:
An assessment process has been put to place as part of the personal plan review process. Goals pertaining to education/training and employment will be added where suitable to personal plans and reviewed quarterly where required if applicable 30/10/2016

Policy on supporting people to access training, education and developmental opportunities has been added to the service policy folder and will be discussed with residents in the advocacy meeting in October 2016

Proposed Timescale: 30/10/2016

Proposed Timescale: 30/10/2016

Theme: Health and Development

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

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

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

Please state the actions you have taken or are planning to take:
Policy in place in the centre as of the 21/09/2016 and will be discussed with residents at the upcoming advocacy meeting in October 2016

Proposed Timescale: 30/10/2016

Proposed Timescale: 30/10/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Referrals to specialist services were not consistently followed up.

26. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
The outlined catheter diary and care plan have been updated. A system for nurses to follow up appointments and update information has been developed 20/09/2016

The appointment has been followed and residents' optical review has been carried out. New appointments log book has been developed.

The responsibility of the nurse to manage the appointments has been clarified and new appointments file has been created.

CNMII will be in charge of weekly drives and outings schedule planning with the nurses, drivers and any other needed staff.

A weekly detailed schedule for each week is created on Fridays and hangs on communication room, this is been done by CNMII.

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inadequate measures had been put in place to protect the wellbeing of residents who received enteral nutrition.

Specialist recommendations were not incorporated into personal plans.

Where evidence based assessment tools were used to assess individual clinical risk, this was not incorporated into care plans.

Care plans in relation to pain management were not followed.

Care plans were not updated when residents' healthcare needs changed

27. 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 care plan of the resident receiving enteral nutrition has been revised and additional measures to ensure his wellbeing and safety has been put to place. This has been communicated to staff at handovers and in additional meeting outlining the issues of concern in July 2016.

Specialist recommendations are included in the new care plans and will be directly implemented in the daily care. Plans to be updated by 30/10/2016

Pain management has been added as an additional part in care plans with clear instructions of how to manage pain with each individual resident.

All care plans are currently being updated and prioritized, five being completed at 22/09/2016 and all remaining by 7/10/2016. As an interim measure the CNM has reviewed all files and made any needed immediate adjustments to insure accurate information in each file. Going forward all care plans are updated as care needs change: the nurse on duty is responsible of updating the plan as required daily.

Proposed Timescale: 30/10/2016

Proposed Timescale: 30/10/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The safe custody and control of medicines requiring additional controls could not be demonstrated at all times.

28. Action Required:
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
It has been highlighted to staff that no medicine is to be removed from safe custody earlier than administering it. Any AER is filled be reviewed by the CNM. Staff will be met individually to discuss the issue and learning will be brought to the staff team via the staff meeting to avoid the re-occurrence.

A clinical governance and auditing system following any errors and follow up to individual staff has been developed and audits carried by senior staff on weekly basis, Finalized 15/09/2016

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All transcribed records reviewed were not complete and inaccuracies/errors were noted.

Two medicines for pain relief were administered four and two hours later than the times prescribed on a consistent basis for the month preceding the inspection.

One prescription outlined that the medicine be administered orally even though the resident requires medicines to be crushed and administered via enteral tube.

Medicines administered did not contain the same active ingredient as those prescribed.

The practice for the receipt of verbal orders within the centre was not safe

29. 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:
All identified non compliances in the main inspection report have been rectified as of 20/09/2016

Spelling errors have been rectified as of 20/09/2016

A clinical governance and auditing system following any errors and follow up to individual staff has been developed and audits carried by senior staff on more weekly basis. Any AER is filled be reviewed by the CNM. Staff will be met individually to discuss the issue and learning will be brought to the staff team via the staff meeting to avoid the re-occurrence.

In relation to the verbal orders it has been confirmed that the nurses take verbal orders but the same is also always confirmed by fax stating the same to the service and the pharmacist.

No only verbal orders are accepted by single staff member without a second person to repeat order or a fax to state the same.

In relation to the eye drops mentioned in the main body of the inspection report, eye drops have been reviewed as of 19/07/2016

A system around medication deliveries and ingredients put in place including:
Pharmacy changed, new one will be doing independent audits on medication ongoing, pharmacy changed 15/09/2016
All Kardexs' reviewed 22/09/2016

In relation to the medication administered via the enteral tube the care plan around peg management and medication has been updated to all medication are now on the kardex as state administration through the external tube as of 30/07/2016

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An appropriate risk assessment had not been completed to guide self administration of medicines.

Inadequate oversight was in place to ensure compliance and concordance with the prescribed medicines.

30. Action Required:

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

Please state the actions you have taken or are planning to take:
It has been communicated to staff in each individuals medication administration file as required in relation to self-medication policy.

A clinical governance and auditing system following any errors and follow up to individual staff has been developed and audits carried by senior staff on constant basis, Finalized 22/09/2016

Outcomes of each medication error audit will be communicated to staff via staff meetings as means of learning. Medication AERs' have also been added to each staff meeting agenda.

The Service's Pharmacy has been changed 15/09/2016. New pharmacist will carry out ongoing independent audits to the medical management and oversight of the service

Pharmacist will be available to answer any queries from residents or staff monthly on site when required or by appointment in between monthly site visits. This will be related to residents in the advocacy meeting in October.

All Kardexs' are revised as of 22/09/2016

A new medical error file is put on place and will be filled for all medicine errors 15/09/2016

Nurses will be responsible for auditing medicines on daily basis and CNMII will audit their monitoring weekly 15/09/2016

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

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:
The annual review did not cover all aspects of care and support in the centre to ensure a quality and safe service was provided.

31. Action Required:
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual

review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
The operation plan for the Limerick Cheshire Services is an action plan which is guided by the Annual Service Review for 2015. This was supplied to the HIQA inspectors on the day of the inspection by the regional manager.

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate clinical and overall governance in the centre which placed residents at risk of a potentially catastrophic outcome.

The Authority did not this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

32. 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:

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Five staff had not completed dysphagia training.

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

Please state the actions you have taken or are planning to take:
Five staff in question have been trained. Any new staff in the service will not support a

resident around nutrition unless they have been through the official dysphagia training.

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Incomplete medication administration records were maintained.

34. 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:
Medication variance form filled for the six occasions and medical AER filled 22/09/2016
A system has now been reviewed relating to the variance in medication and they will be reviewed weekly by CNMII. Actions will be added to service action plan.

Proposed Timescale: Completed 7.11.16

Proposed Timescale: 07/11/2016