



Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Kerry Cheshire
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Kerry
Type of inspection:	Announced
Date of inspection:	25 April 2018
Centre ID:	OSV-0003447
Fieldwork ID:	MON-0021787

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The mission of Cheshire Ireland, as set out in its statement of purpose, is to work with the resident to design supports that help residents to "live the best possible life" and to work with the residents in a manner which "is respectful and honest". This centre provides support to residents 24 hours per day, seven days per week. Staff support residents with a variety of disabilities such as stroke, multiple sclerosis and cerebral palsy. The age range of residents varies from 30 to 65 and caters for both male and female residents. The centre is a single-storey purpose built apartment complex in Co. Kerry. Each resident's apartment has an open plan ground floor, single occupancy bedroom, kitchen and living area. Each apartment has accessible toilet and shower facilities.

The following information outlines some additional data on this centre.

Current registration end date:	30/09/2018
Number of residents on the date of inspection:	12

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
25 April 2018	10:20hrs to 21:15hrs	Margaret O'Regan	Lead

Views of people who use the service

The inspector spoke with a number of residents living in this service. All residents with whom the inspector met, appreciated aspects of their care, in particular having self-contained apartment type accommodation. This greatly facilitated their independence which residents valued. It allowed residents freedom to enter and leave the centre via the privacy of their own front door.

All residents with whom the inspector met were engaged in activities outside of the centre, such as attending college, being involved in a social club, receiving therapies and socialising locally. Residents commented on the increased focus there had been on promoting activities for residents and the increased availability of transport to facilitate these activities. In addition, the provider facilitated in-house activities such as a monthly social evening where residents partook in a communal dinner and an activity such as a film or a karaoke session.

While residents had positive comments about the service, some also expressed sentiments that suggested it was a challenge for residents and staff to express their views in an open and safe way. This was of concern to the inspector who requested that this be investigated as a matter of priority by the provider. The outcome of this investigation is awaited.

Residents greatly benefited from having a personal assistant service funded by the Health Services Executive. All residents with whom the inspector spoke was complimentary of this provision.

Capacity and capability

From information gathered on inspection, the inspector had concerns about the robustness of the management systems to facilitate and support staff and residents to raise concerns. In light of this, the inspector required further information to satisfy themselves that the provider had the capacity and capability to deliver a safe and quality service. Following the inspection the inspector issued an provider assurance report. This was a request for assurance around the management systems and how these systems supported residents and staff to raise concerns that impacted on the quality and safety of service provided. The provider responded to this request by instigating an investigation. The report from this investigation is to be submitted to HIQA by 7th June 2018. Upon receipt and evaluation of this report,

a further inspection will be conducted.

This is a purpose built centre. On the day of inspection, it was found to be clean and generally well-maintained. Indications were that there were adequate resources to maintain the premises in a suitable state of repair and decoration.

While staffing levels had increased in the morning and afternoon since previous inspections, there continued to be challenges in ensuring there were sufficient staff on duty at all times. To address the deficits, agency staff were employed. The person in charge reported staff from the agency were regular workers in the centre, thus minimising the disruption to staff continuity. The person in charge informed the inspector that recruitment of new staff was an ongoing process.

Staff and residents stated staffing levels were such that assistance would sometimes be delayed and that there wasn't enough time to do all what should be done. This was a particular issue when residents attended appointments and a staff member traveled with them, thus reducing the staff compliment in the centre. Staff reported that the local management team assisted with hands on duties at times of pressure on staff resources.

A limited number of regulations were inspected against on this inspection, due to the issues that arose and which necessitated a provider assurance report on the functioning of the management systems.

A further inspection is to follow once the report from the investigation has been completed.

Registration Regulation 5: Application for registration or renewal of registration

Application for renewal of registration was received on 18th April 2018.

Judgment: Compliant

Regulation 14: Persons in charge

There was a full time person in charge involved in the day to day operational management of the centre.

Judgment: Compliant

Regulation 15: Staffing

The number of staff available in the centre was not appropriate to meet the assessed needs of residents. However, the provider was engaged in a staff recruitment process and as an interim measure, agency staff were employed, regular staff worked increased hours and management staff assisted with hands on duties when necessary.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector was not satisfied that the management systems in place adequately facilitated staff to raise concerns about the quality and safety of the care and support provided to residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was updated on 8th March 2018. It complied with the requirements of regulations.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The chief inspector was informed by the provider of the procedures and arrangements in place for the management of the centre during the absence of the person in charge. This person was involved in the day day operations of the centre and met with the inspector during the course of inspection.

Judgment: Compliant

Quality and safety

Supports were in place to help residents exercise their rights and express their opinions. This was facilitated through the residents forum, the complaints process and by direct communication with staff. Improvements had been made in this area, such as the facilitation of the resident forum meetings by a person external to the centre. Also, the inspector was informed that residents were active in exercising their right to complain and their complaints were followed up upon. However, as discussed elsewhere in this report, the inspector also noted challenges residents experienced in making their views heard. This issue is being investigated by the provider.

The centre was designed to promote residents' independence. The statement of purpose for the centre emphasises this core principle. The provision of a personal assistant service, funded by the Health Services Executive, provided residents with opportunities to get out and about and partake in their individual chosen activities. This level of service and independence was most keenly felt by residents who transitioned to the centre from more restricted environments. It was something residents valued greatly. The inspector noted that staff welcomed the increased level of opportunities available to residents to help them engage in meaningful activities. Staff also remarked that there were opportunities for the provider to further support the integration of residents into the local community. Some staff took initiatives in this regard by accompanying residents to sports events or to the local hostelrys.

The approach to care was individual and much work had been undertaken by Cheshire Ireland in developing new assessment tools, in particular health assessment tools. These assessment were in the process of being implemented by a member of the local management team, who showed enthusiasm for this new process.

Staff displayed a commitment and an interest in their work; however, the inspector also noted staff felt a lack of appreciation from their employer, for the work they did. This matter is part of the provider's investigation into the management systems mentioned elsewhere in this report.

Each resident's privacy was respected, with residents having their own rooms. These rooms were decorated according to individual preferences.

There were inadequacies in some of the practices and in the documentation pertaining to risk assessment and the fire safety arrangements. For example;

* fire drills indicated two residents did not routinely evacuate when fire drills took place. There was no risk assessment on file for the risk of residents not evacuating in the event of a fire.

* a fire safety audit report dated 2014, indicated eight people were needed to assist residents to move from one area of the centre. The staffing roster indicated eight staff (including management staff) were not routinely on duty. There was no risk assessment on file around the risk of having insufficient staff on duty to

support residents to evacuate in the event of a fire.

* the fire drills did not detail the plan of action for when residents refused to evacuate. From records seen, two residents frequently did not partake in fire drills

* there were no available records for night-time fire drills

* the fire safety policy dated 18/11/2017 stated staff fire safety awareness training would be recorded in the register; however, the last training recorded in the register was on 14/04/2016 and not all staff were recorded as having attended this.

* the personal emergency egress plan was not in the file for one resident

* there was lack of clarity as to when the last emergency lighting inspection took place as the report was not dated

* the centre did not have a generator but the fire safety policy dated November 2017 stated the centre did have a generator.

Regulation 11: Visits

Residents were facilitated to receive visitors in accordance with their wishes.

Judgment: Compliant

Regulation 12: Personal possessions

The person in charge ensured that, as far as reasonably practicable, each resident had access to and retained control of personal property and possessions and, where necessary, support was provided to manage their financial affairs. In so far as reasonably practicable, residents were facilitated to bring their own furniture and furnishings into the rooms they occupied.

Judgment: Compliant

Regulation 13: General welfare and development

Overall, the registered provider provided residents with access to facilities for occupation and recreation; opportunities to participate in activities in accordance

with their interests, capacities and developmental needs; and supported residents to develop and maintain personal relationships and links with the wider community.

Judgment: Compliant

Regulation 17: Premises

The premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. It was clean and suitably decorated.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider prepared a guide in respect of the centre and made this available to residents. This was revised in 2018.

Judgment: Compliant

Regulation 26: Risk management procedures

There were inadequate measures and actions in place to control the fire safety risks identified.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire fighting equipment was provided. However, there were inadequacies in some of the practices and in the documentation pertaining to fire safety arrangements.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment of the health, personal and social care needs of residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant

Compliance Plan for Kerry Cheshire OSV-0003447

Inspection ID: MON-0021787

Date of inspection: 25/04/2018

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <p>Agency Support will be maintained in the service as required. A Specified Purpose Contract has been advertised to cover staff currently on sick leave. From these interviews, in addition to filling the post, we would also anticipate to build up our relief panel which would cover annual and sick leave. Interviews for this post to be held on July 5th 2018.</p>	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Management Investigation has been completed as requested by the Provider Assurance Report. The report along with findings and action plan has been submitted to HIOA as agreed. The Provider Nominee has scheduled a staff meeting on the 28th of June to outline the findings and actions from the report. All recommendations to be discussed and implemented in the service in consultation with staff. A representative staff working group will be brought together to ensure ongoing discussion and information sharing in order to effect improvements in the service, including support for staff to raise a concern, as per the Action Plan submitted in the Assurance Report and ensure that effective arrangements are in line with Regulation 23 (3) (a) and (b). The group will be chaired by the PIC and/or designate and governance and oversight will be through the Regional Manager on a monthly basis through supervision and through quarterly attendance at staff meetings.</p>	

Regulation 26: Risk management procedures	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <p>Risk assessment completed on 18/06/2018 regarding fire drills. Emergency lighting report updated with signature and date on 13/06/2018.</p>	
Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <ul style="list-style-type: none"> • Risk assessment completed on 18/06/2018 regarding fire drills. • Explanation on fire safety audit to be completed by Jason Cooling O'Regan (Head of Health & Safety) by 27/06/2018. (See attached) • Fire drill to be completed with staff compliment on night duty during day time hours, three completed – two on 09/06/2018, another on 27/06/2018. (See attached). • Copy of fire safety training updated in register on 07/06/2018. • Copy of Personal Emergency Egress Plan for one service user inserted to the Fire Register on 25/04/2018. • Emergency Lighting Certificate completed by Chubb on 13/06/2018. • Fire Safety Policy updated on 25/04/2018 to reflect that there is no generator on site. 	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
15 (1)	Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	27/06/2018
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	01/07/2018
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to	Not Compliant	Orange	27/06/2018

	in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.			
28 (2) (b)(ii)	Make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	27/06/2018
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	01/07/2018
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	27/06/2018
Regulation 28(4)(a)	The registered provider shall 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.	Not Compliant	Orange	17/07/2018

Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	27/06/2018
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