Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

## Issued by the Chief Inspector

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| Name of designated centre: | Waterford Cheshire |
| Name of provider: | The Cheshire Foundation in Ireland |
| Address of centre: | Waterford |
| Type of inspection: | Unannounced |
| Date of inspection: | 30 April 2025 |
| Centre ID: | OSV-0003457 |
| Fieldwork ID: | MON-0045444 |

## About the designated centre

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

Waterford Cheshire was established in 2003 and provides accommodation and support in a purpose-built facility of self-contained apartments to adults with physical disabilities and neurological conditions. Individuals seeking to access services must be aged between 18 and 65 when they first arrive.
The service can accommodate 16 Service Users in total. Fourteen permanent residential apartments are available and two apartments are used to provide respite services. Most of the apartments have one bedroom, some have two bedrooms. All apartments have a kitchen/dining room and accessible bathroom.
Many of the people accessing the service have high physical support needs and the service endeavours to provide the supports required to enable each person to maintain the best possible health and to remain as independent as possible, for as long as possible. People living in the centre direct and participate in their own care.
The centre operates all year round and is staffed 24/7. A mix of nursing and support workers provide assistance to residents.

**The following information outlines some additional data on this centre.**

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|---|---|
| Number of residents on the date of inspection: | 15 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as 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 |
|---|---|---|---|
| Wednesday 30 April 2025 | 09:00hrs to 17:00hrs | Linda Dowling | Lead |
| Wednesday 30 April 2025 | 09:00hrs to 17:00hrs | Marie Byrne | Lead |

## What residents told us and what inspectors observed

From what residents told them, and what inspectors observed, this was a well-run centre where residents were leading busy lives and engaging in activities of their choosing. This unannounced inspection was completed to review the arrangements the provider had 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, and the National Standards for Adult Safeguarding (Health Information and Quality Authority and the Mental Health Commission, 2019). The inspection was completed by two inspectors of social services over the course of one day.

Over the course of the inspection, inspectors had an opportunity to meet and communicate four of the 16 residents living in the centre, three staff members and the person in charge. This inspection had positive findings, with the majority of regulations inspected found to be compliant. Residents were found to be safe and protected from abuse. However, inspectors found that improvements were required in relation to risk management and this will be discussed later in the report.

Waterford Cheshire providers full-time residential care for up to fifteen adults and has one respite apartment that five adults utilise on a rotational bases. Most of the residents living in the centre have high physical support needs. The centre comprises of one central building and 16, one or two bedroom apartments. Some apartments are attached to the main building with their own front door and access to garden space and some are within the main centre both downstairs and upstairs. The main building also housed administration offices and communal space which residents could utilise. All apartments have a kitchen/dining room and accessible bathroom. Residents have access to televisions, mobile phones, computers and music systems. There are a number of service vehicles to support residents to access their local community and some residents own their own vehicle. One resident proudly showed the inspector their apartment and where they stored all their clothing and other personal belongings. They told the inspector they liked living in the centre but would love a home of their own with a garden. This resident showed the inspector their kitchen and washing machine and explained how they manage cooking their meals and taking care of their own laundry.

There were 15 residents living in the centre on the day of the inspection. During the inspection, inspectors had an opportunity to meet and engage with four of them. They had a variety of communication and physical support needs. Residents told the inspectors they liked where they were living and for some it felt like home. One resident had recently transitioned from respite to full time residential and told the inspector they were very happy. They told the told the inspector they had planned a party with all their friends and family to celebrate becoming a full-time resident.

Residents in this centre were not supported full-time, they had a call bell system in place to request support when required. The provider had been made aware of

some concerns in relation to the response time to call bells and residents left without access to their call bell. Residents told the inspectors that they had a call bell in place if they needed support or assistance at anytime day or night. One resident had a call bell fixed in place on their bed as a control measure to a recent incident, another resident highlighted to the inspectors that they could use their voice activated mobile phone to call staff should they require support. One resident reported the response time to the call bell has improved in recent months.

Some residents utilised a local day service on a full time bases, one resident had paid employment a number of days per week, other residents had scheduled visits home to their families. One resident informed the inspector their family enjoy visiting them at the centre and they also enjoy going away on holidays with them.

Overall, residents were positive about where they lived and the activities they had access to, they spoke about how they felt safe and staff were respectful to them. Staff were observed to knock and seek consent before entering a residents apartment or bedroom.

Resident and family input was sought as part of the provider's annual and six-monthly reviews. In 2024, 14 out of 15 residents completed surveys which overall contained mostly positive commentary on care and support in the centre.

In addition to the surveys, 15 compliments were received about the service in 2024 and resident feedback was also sought at residents' meetings. In line with their feedback, resident meetings were changed from monthly to quarterly and a monthly newsletter was developed. From a review of the latest resident meeting minutes, discussions were held around the findings of audits and reviews in the centre, upcoming events and activities, advocacy, safeguarding and staffing matters. Two recently published newsletters were reviewed and these contained information on areas such as residents' achievements, staffing matters, respect and dignity, the complaints process, road safety, health and well-being, and the FREDA principles (fairness, respect, equality, dignity and autonomy).

There was information available and on display about areas such as, the provider's annual review, safeguarding, complaints, the confidential recipient and a memo to alert residents to the dates of quarterly resident meetings and the dates the monthly newsletter would be published.

In summary, it was evident that residents living in this centre were receiving a good service which was promoting their rights, and ensuring that they were safeguarded. Residents appeared to be comfortable and content in their home.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

## Capacity and capability

Overall, inspectors found the provider's systems for oversight were providing effective in respect to safeguarding in this centre. There were systems in place that were proving effective in keeping residents safe. The Inspectors found that staff had access to training and refresher training in line with the organisation's policy, including safeguarding training. Information was shared with the staff team at handovers, by email and at staff meetings to ensure that all staff were kept informed of control measures in place to keep residents' safe.

Safeguarding was reviewed at staff meetings, in the provider's annual review and six-monthly review, at residents meetings and in monthly newsletters.

## Regulation 15: Staffing

Inspectors found that the provider had put considerable resources into recruitment in recent months which resulted in the successful recruitment of five staff, two of whom were on boarding at the time of the inspection. In addition, they had increased the number of staff available on the relief panel. Based on a review of rosters, this was found to be having a positive impact on continuity of care and support for residents. There was a reduction in the number of shifts covered by agency staff. For example, in a sample of rosters reviewed over a three month period, an average of two shifts per month were covered by agency staff and the remainder were covered by regular or relief staff. New staff were scheduled for shadow shifts to ensure they had an opportunity to become familiar with residents' care and supports needs and to provide residents an opportunity to meet and feel comfortable in their presence prior to being supported by them.

Interviews were ongoing to fill some management positions including an assistant manager and a care co-ordinator at the time of the inspection. Interviews were being held on the day of the inspection.

A sample of three staff files were reviewed and these were well-maintained and contained the required information. This included Garda or police vetting, reference checks and valid identification for staff.

Judgment: Compliant

## Regulation 16: Training and staff development

Inspectors reviewed the training matrix for all staff members and found all staff had completed safeguarding training. The inspectors reviewed a sample of certificates of training for three staff and cross referenced them with the training matrix.

Additionally, in response to incidents or residents' assessed needs additional training was provided. For example, in response to concerns relating to residents skin integrity bespoke training was in the process of being rolled out for the staff team at the time of the inspection.

An action identified in the provider's most recent annual review related to providing focused information sessions for staff on the FREDA principles. These sessions were planned during staff meetings or at staff supervision to guide care practices and to embed a human rights based approach to care and support in the centre.

Inspectors spoke with two staff who reported that they were well supported by the local management team and aware of how to report any concerns they may have. A sample of supervision records for three staff were reviewed and discussions had been held around staff's roles and responsibilities, residents' goals and well being, complaints and compliments, incidents and safeguarding.

Inspectors also reviewed a sample of two recent staff meeting minutes, and discussions were regularly held in relation to staff's roles and responsibilities, training, complaints, compliments and safeguarding.

Judgment: Compliant

## Regulation 23: Governance and management

The inspectors found good systems in place and a defined management structure, there was a stable team lead by a suitable person in charge.

Inspectors found that the provider was implementing a number of control measures to reduce presenting risks relating to incidents, accidents and safeguarding. However, there was an absence of a general safeguarding assessment and safeguarding risk assessment for some residents. This will be discussed under Regulation 26: Risk Management.

Based on a review of rosters and discussions with residents and staff it was evident that the person in charge was present and available to them on regular basis. They received support and supervision from a person participating in the management of the designated centre. As previously mentioned, interviews were ongoing to fill a number of key management roles in the centre including an assistant manager a care co-ordinator and two senior support staff. In the interim, key management tasks were being delegated to and completed by existing members of the management team including a care co-ordinator, clinical nurse manager and two senior support staff who were on specific purpose contracts.

The provider's last annual review and two six-monthly reviews were found to be highlighting areas of good practice and areas where improvements were required. There was a detailed section in the latest annual review about incidents and safeguarding which detailed the number of incidents and safeguarding concerns and

the provider's response to these including any lessons learned and the additional measures implemented to keep people safe. The provider found that 9 of the surveys submitted as part of the six monthly review did not contain any additional information on the questions asked or rationale for responses so planned to attempt to improve the format moving forward. In addition the provider had developed an action plan in response to some areas where residents identified as requiring improvements in areas such as communication, the effectiveness of the call bell system, complaints management, and the induction pathway for staff.

Inspectors reviewed a sample of area-specific audits on areas such as medicines, infection prevention and control, restrictive practices and falls. Each audit had an action plan which detailed the required actions. From a review of the action plans there was evidence that the actions were tracked and leading to improvements.

Judgment: Compliant

## Quality and safety

Overall, the inspectors found that the quality and safety of care provided for residents, were of a good standard. The inspectors observed that residents had opportunities to take part in activities and to be involved in their local community. Residents were actively making decisions about how they wished to spend their time, and were supported in developing and maintaining connections with their family and friends.

The apartments were suitable to the needs of the residents living there and residents also had access to communal space available.

The management and staff team were striving to provide person centred care to the residents of the centre. This meant that residents were able to express their views, were supported to make decisions about their care and staff team listened to them. Residents had access to a complaints and complements system and residents meetings were held quarterly along side a monthly newsletter.

Safeguarding concerns were being identified, reported to the relevant authorities and managed well within the centre. However, improvements were required in the management and recording of risk in the centre.

## Regulation 10: Communication

Residents were assisted to communicate in accordance with their assessed needs and wishes. Easy read information on safeguarding, advocacy, the complaints process and rights were available to the residents which helped support them to

communicate their feedback on the quality an safety of care provided in the service.

Staff also had regular meetings and/or check ins with the residents where they could communicate, discuss and address any issues the may have in the centre.

Residents also had access to telephones and other such media like internet, televisions, radios and personal computers.

One resident used Irish sign language as their preferred method of communication and the inspectors observed the staff and person in charge using these signs to communicating with the resident.

Judgment: Compliant

## Regulation 17: Premises

Overall, the premises was bright and spacious. The inspector viewed four residents apartments and found them to be personalised with items of value, achievements, art work, family photos, one resident had a fish tank, one had a display of CD's. For the most part apartments were well kept and were clean. Some residents had the tiles in their en-suite changed and these were easier maintain. The provider plans to make changes to all en-suite over a period of time. The provider had identified that each apartment required a deep clean at least twice a year and this had been scheduled with their cleaning company.

As part of the inspection the inspectors completed a walk around of the centre and found it to be accessible, corridors were wide and majority of doors were automated to allow residents ease of access. Where required residents had access to hoist facilities and their apartments were laid out to meet their assessed needs.

Judgment: Compliant

## Regulation 26: Risk management procedures

Although there were policies and procedures in place in the centre there was a number of improvements required to comply with regulations and best practice.

For the most part, inspectors found that residents, staff and visitors were protected by the risk management policies, procedures and practices in the centre. The provider had a risk management policy which had been reviewed in line with the time frame identified in the regulations and it contained information required by the regulations.

Inspectors found that staff and the local management team were recognising the

risk relating to the 17 allegations or suspicions of abuse which had been notified to the Chief Inspectors of Social Services since January 2024 to date, however, there was no general risk assessment in place for this centre relation to safeguarding. In addition, where specific risks presented for a resident, individual safeguarding risk assessments were not in place for them.

There had been a number of complaints in relation to call bells in the centre. The provider had responded and contacted the company who provides the system to explore alternatives to the current system; however no suitable alternatives were available. In response, a protocol had been developed and was being implemented at the time of the inspection. There was a risk assessment in place; however this related to the functioning of the call bell system, rather than the presenting risk of call bells not being answered in a timely manner or call bells not being in close proximity of residents.

Inspectors reviewed the clinical risk register available in the centre and found that it was not reflective of the presenting risks in this centre. For example, a risk assessment for pressure sores had been risk rated orange, however, the risk of pressure sores in this centre was well managed with appropriate actions taken therefore it was not an orange rated risk. The clinical risk assessment in place were from a provider level and were not tailored to the specific needs of the residents in this centre. Although the staff could refer to the guidance on the clinical risk register it did not guide there practice specific to the needs of the residents in this centre.

Following a review of a sample of residents' risk assessments inspectors found that the majority of the required risk assessments were in place; however, some of these had not been updated following incidents. A sample of six general risk assessments were reviewed and these did not contain a date of development or review.

Incidents and accidents were documented and reported. They were monitored by the management team and it was evident that follow up actions were taken; however, inspectors found that trends relating to incidents and learning as a result of a review of incidents was not regularly discussed at staff meetings in 2025.

During the inspection, inspectors observed there were outstanding fire works to be completed to the premises as outlined in the providers previous compliance plan in 2023, the inspectors reviewed the plan in place to complete this work and sought further assurance from the provider after the inspection.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

The provider had a restrictive practice policy in place that was in date and due for review in June 2025. The policy defines restraint and details the difference between a restraint or and enabler. The policy also provides context and guidance on consent

and capacity and the use of restraint in an emergency.

The inspectors reviewed the log of restrictions in place within the designated centre and found them to be reflective of any restrictions used. These had also been reported to in line with regulations to the Chief Inspector of Social Services. Restrictions included lap belts, bed rails, positioning aids and foot straps. The person in charge informed the inspectors of the providers' rights committee and their purpose is to review higher level restrictions. The person in charge had sent a referral to the rights committee detailing a possible restriction they were considering to protect the health of one resident.

All restrictive practices are reviewed annually with the residents. The residents, where possible, gives consent and signs the document.

It was evident that the provider was implementing changes to reduce restrictions where possible. For example, one resident's apartment had been fitted with an automated door to allow them freely enter and exit their apartment this resulted in the removal of the previous restriction where they required support for this task.

Judgment: Compliant

## Regulation 8: Protection

There were systems in place to safeguard residents' finances. For example, there was a money management policy in place, residents were supported by staff to review their income and expenditure, examine their bank statements and to develop budgets, if they wished to. Those who wished to, or who were assessed as requiring support, were supported to develop money management plans, to log receipts of spending and to store their finances securely in the centre.

The provider had an intimate and personal care policy in place which was being regularly reviewed and which contained sufficient detail to guide staff practice.

The inspections found that, safeguarding concerns were being identified, reported to the relevant authorities and managed with appropriate control measures in place within the centre. There was ongoing review of the safeguarding plans to sure it was effective. Two staff who spoke with inspectors had completed safeguarding training and were aware of their roles and responsibilities should there be an allegation or suspicion of abuse. They were aware of the different types of abuse and named some of the indicators of abuse.

Residents were also kept informed about their right to raise a concern and how to make a complaint to the staff team or the person in charge. The complaints, complements and feedback process was on display around the centre and was seen to be utilised by residents. One resident told the inspector that they were aware of the complaints process but never had any need to use it, they stated most things

can be resolved with a conversation.

Judgment: Compliant

## Regulation 9: Residents' rights

From review of documentation, discussion with staff members, residents, person in charge and inspectors observations, residents were supported to exercise their rights. Residents were provided with relevant information in a manor that was accessible to them and given time to make a decision. They were supported to make choices about how the centre was presented. On review of resident meeting minutes some residents requested they create a vibrant space in the reception area of the centre. They were supported by the staff team and worked together to arrange a local artist to come and create colourful displays on the walls of the reception area. The residents felt it was important to include the quote "learning through listening" which came from the founder of the organisation. It was recorded at a subsequent residents meeting that this was simply spectacular, residents were very proud of their achievement. The inspectors viewed this artwork and space on arrival and found it to be bright and welcoming.

Residents had voiced opinions on weekly residents meetings and agreed that monthly newsletters and quarterly residents meetings would be better, this appears to be working better for residents and they are engaging well.

One resident attended the launch of the Assisted Decision Making (ADM) commencement, they were very proud to have had the opportunity to be present at this launch as it is a topic that they feel passionate about, they showed the inspector photos of them with relevant people at the launch. They were also involved in the launch of the easy-to-read version of the HSE national consent policy.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Waterford Cheshire OSV-0003457

## Inspection ID: MON-0045444

## Date of inspection: 30/04/2025

**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 26: Risk management procedures | Not Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A general safeguarding risk assessment has been completed for the service with input from Cheshire's National Adult Safeguarding Lead, National Risk Manager and Regional Manager.

The existing general call bell risk assessment has been revised to include measures in place to address the risk of delay's in responding to call bell activation and incident's whereby a service user does not have access to their call bell when alone in their apartment.

Where identified on the day of the inspection, the care plans and risk assessment for individual service users have been created with input from the person, to address specific safeguarding risks. A review of all safeguarding notifications is underway for 2024 and 2025 to ensure the corresponding care plans and risk assessments identified are in place. This will be completed by 07/07/2025.

A review of all service user risk assessment has commenced to ensure review dates are set for each one. This will be completed by 07/07/2025.

All general risk assessments are under review which will be completed by 05/08/2025.

The service template for staff team meetings has been revised to include a review of relevant incident's to ensure the learning from each is identified and shared with the staff team.

An update on the outstanding fire works has been sent to HIQA on 09/05/2025.

Provider-Level Clinical Risk Register: This register shows risks identified at the provider

(national) level. It does not reflect the current clinical risks in this centre.
For local risks, please refer to the Person-Centred Risk Assessments on iPlanit. These are reviewed and updated regularly on the iPlanit system.

Document Management: When using electronic systems or shared folders, Cheshire will clearly label documents to avoid confusion. Examples include:
• National Clinical Risk Register
• Local Environmental Risk Assessments
To address this:
• The National Clinical Risk Register is now kept separate from Local Environmental Risk Assessments Folder.
• Both are clearly marked and stored in separate folders.
Staff have been reminded that up to date clinical risks for each resident are recorded in iPlanit.

## 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 |
|---|---|---|---|---|
| Regulation 26(2) | The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. | Not Compliant | Orange | 05/08/2025 |