Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	St. Patrick's Cheshire - Leonardsville and Abbey Close
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Carlow
Type of inspection:	Announced
Date of inspection:	07 November 2018
Centre ID:	OSV-0003437
Fieldwork ID:	MON-0021786

About the designated centre

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

The provider describes the service as providing support to adults who have physical and sensory disabilities or neurological impairments and require a medium to high level of support.

The designated centre includes three bungalow style houses in a community housing estate, and a group of eight apartments surrounding a landscaped courtyard. Each of the homes is self contained.

The following information outlines some additional data on this centre.

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
07 November 2018	11:00hrs to 21:00hrs	Julie Pryce	Lead

Views of people who use the service

The inspector met and spent time with residents, including visiting some of the apartments when invited by the residents. Residents were happy with their homes, which they had decorated according to their preferences. The inspector observed that people were very comfortable in their homes, which were arranged in accordance with both their needs and preferences.

Residents told the inspector that they were happy with how they had decorated their homes, and for the most part with the service they received. However some people did not feel that they had enough support for activities of their choice.

Capacity and capability

There were systems in place to ensure that there was oversight of the quality and safety of care and support in the designated centre. There was a clearly defined management structure in place with clear lines of accountability. The person in charge was a regular presence in the centre, and was well known to al the residents and staff.

The person in charge was appropriately skilled, experienced and qualified, and had a implemented various processes in relation to monitoring of the service, and therefore improving the quality of the service.

Various audits had been undertaken including an audit of safeguarding, of money management and of medication management. Any areas for improvement identified during these audits were overseen at a monthly 'Audit action meeting' which reviewed the progress of all actions. Improvements for residents as a result of this process included a review and ongoing improvement in medication management, and the progression of maintenance and improvements in facilities.

A system of meetings was in place including staff meetings and senior management meetings. The content of these meetings was comprehensive and included all aspects of service delivery. All agreed actions from these meetings reviewed by the inspector had been completed.

The numbers of staff were sufficient to meet the personal care and physical support

needs of residents. However, there were a limited number of hours available to most residents for activities or supported outings, and these hours were mostly used in weekly grocery shopping and other errands. There was insufficient evidence that there was staff time available for other activities, hobbies or assisted personal development for residents. This was confirmed by residents, and by discussions that they had held with staff.

Staff had received mandatory training, and training in specific areas pertinent to the needs of residents. Staff had received training in various clinical aspects of care including bowel care, the management of dysphagia and catheter care. However, the responsibility for delivering the training to the staff of this centre and another designated centre operated by the provider fell with the two nurses who were employed by the service.

There was not evidence that the nursing cover arrangements were adequate to meet the needs of residents, given the high levels of physical and medical issues. The time taken out of care delivery to facilitate training exacerbated this issue. However, even without the time committed to providing training there were significant periods of time where there was no nursing cover.

The provider had made effective arrangements to supervise and support staff to provide good care to the residents. Staff supervision was formally conducted on a three monthly basis, and a schedule was in place to manage this. A sample of staff files contained all the information required by the regulations, and an audit had been conducted by the service which found that all files were complete.

Continuity and consistency of staff was managed by the use of a core staff team and a relief panel of staff who were all known to the residents. Staff engaged by the inspector were knowledgeable in relation to the care needs of residents and the required interventions, both in relation to personal care and individual social issues.

The provider has made arrangements to receive and respond to complaint information. There was an appropriate complaints policy in place, and a log of any complaints was maintained which included information as to whether the complainant was satisfied with the outcome of the complaint. The person in charge kept oversight of any complaints which were reviewed monthly.

Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, had a detailed knowledge of the support needs of residents and was involved in oversight of the care and support in the centre.

Judgment: Compliant

Regulation 15: Staffing

The numbers of staff were adequate to meet the personal care needs of residents, however the staffing arrangements to provide for social support and development required review. The arrangements for the provision of nursing cover, in relation to the medical and nursing needs of residents, required review.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training and additional training specific to the needs of residents, and were appropriately supervised.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place which identified the lines of accountability and authority. There were effective monitoring systems in place.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose included all the required information and adequately described the service.

Judgment: Compliant

Regulation 31: Notification of incidents

All the necessary notifications had been made to HIQA within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place which was available in an accessible version

Judgment: Compliant

Quality and safety

Residents were generally supported to enjoy a good quality of life in this centre. Each resident had a personal plan in place and they had been involved in the development of these plans which were regularly reviewed. The plan were based on various assessments both relating to health care and social care needs which supported good outcomes for residents. .

An individual lifestyle plan was undertaken annually for each resident, and goals were set during this process. Accessible versions were available and progress toward goals was documented. The provider was looking for ways to improve this system and the inspector saw that a new system of personal planning was underway, and had been completed for several residents. There was an emphasis on

communication in personal plans, and guidance for staff was included.

There was information readily available to residents in a communications folder. Each resident had one of these folders which contained information such as the complaints policy, how to be involved in the running of the centre, and any reports on the centre.

The provider was supporting the healthcare needs of residents. There were detailed healthcare plans in relation to address all the assessed needs of residents, and the implementation of these was recorded. However the lack of a nurse on alternate weekends had a negative impact on required nursing interventions such as the changing of dressings.

A quarterly health review was undertaken, together with continual monitoring of the healthcare needs of residents. Where required referrals were made to allied healthcare professionals, however there was no psychology service available to residents, even where there was a clearly assessed need. Where residents required the input of a dietician, this service was also unavailable.

Each resident had a medication self assessment completed, and was supported to manage their medication in accordance with their needs. Medication management was appropriate and safe for the most part, although the service did not have a system of stock control in relation to reconciliation of stock. The pharmacist attended regularly and took a stock count to ascertain the re-ordering requirements, but this was not checked against medications administered. There was therefore no system of detecting discrepancies in medicinal products' stocks to inform reporting and investigation.

There was, however a regular medication audit which examined the safety of practices other than stock control, and which resulted in an action plan which was monitored by the audit monitoring process.

Any medication errors were recorded and reported, and monitored with the accident and incident monitoring. The reporting of incidents was done by the submission of a form detailing the incident. All accidents and incidents were then trended and overseen a monthly senior management team meetings.

A system of risk management was in place whereby risks were identified and rated, and escalated as necessary, for example to the health and safety manager. However the information in the risk assessments was not always appropriate or in sufficient detail. For example, the risk assessment in relation to behaviours of concern appeared to be an individual risk assessment, and did not include information about the management of the service wide risk. There was no risk assessment in place in relation to the use of restrictive interventions. While there was a risk assessment in place in relation to lone working, it did not reference the practice of lone workers making contact every hour, and did not account for the practice of night staff pairing up when out on the grounds of the campus at night.

There were systems in place in relation to fire safety, and a detailed risk assessment had been developed around this area. A detailed audit of fire safety was undertaken

regularly, and there was a regularly reviewed personal evacuation plan in place for each resident.

There was a smoke alarm in each apartment and bungalow, and the fire alarm was monitored by a telephone on-call system. This system was reliant on the phone system, which had been down on three occasions in the previous eighteen months. While additional checks were put in on these occasions, and the alarm system was linked to a control centre which contacted the resident, there was insufficient evidence that this system was appropriate to the individual needs of all residents.

There were systems in place in relation to the safeguarding of residents. All staff had received training in the protection of vulnerable adults, and staff were aware of their role in protecting residents from abuse. A safeguarding questionnaire had been implemented as part of the formal supervisions meetings, and a safeguarding audit had been completed. All required notifications had been submitted to HIQA as required, and any issues had been followed up promptly and appropriately, including a safeguarding plan and immediate improvements in the systems for supporting residents with their personal money.

Where residents required support with behaviours of concern there were behaviour support plans in place which included guidance for staff both in the prevention of challenging behaviour and in the management of any incidents. While there were very few restrictive interventions in place, there was insufficient evidence in one situation that the intervention was the least restrictive to ensure the safety of the resident.

Regulation 10: Communication

There was clear guidance relating to communication, and this was observed in practice.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the premises was appropriate to meet the needs of the residents.

Judgment: Compliant

Regulation 20: Information for residents

Information was readily available to residents.

Judgment: Compliant

Regulation 26: Risk management procedures

While there were processes were in place to assess and mitigate identified risks, improvements were required in some risk assessments and risk management plans.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Various precautions had been taken against the risk of fire, however there was insufficient evidence that the phone alarm system was suitable to meet the needs of all residents.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

For the most part there were arrangements in place to support safe medication management practices, however, there was no system of system of stock reconciliation to ensure the detection of discrepancies.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place based on an assessment of needs. Plans had been reviewed regularly and were undergoing further improvement.

Judgment: Compliant

Regulation 6: Health care

Not all healthcare needs were met due to the lack availability of allied health professionals and arrangements for nursing cover.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Appropriate systems were in place to respond to behaviours of concern, however the management of some restrictive practices required review as it was not demonstrated that they were the least restrictive option available to mitigate the risk.

Judgment: Substantially compliant

Regulation 8: Protection

Appropriate systems were in place in relation to safeguarding of residents.

Judgment: Compliant

Regulation 9: Residents' rights

While residents each had their own home, night duty staff were located in one of the residents' homes.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. Patrick's Cheshire - Leonardsville and Abbey Close OSV-0003437

Inspection ID: MON-0021786

Date of inspection: 07/11/2018

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A Business case was submitted to HSE in May 2018 in relation to the required social supports and clinical needs. • The PIC, Regional Manager, and Head of Operations are scheduled to meet with HSE on March 4th 2019 to discuss the additional clinical and social requirements.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Fire and Lone Worker risk assessments and risk management plans are being reviewed by the Cheshire Ireland's National Health Safety & Risk Manager to identify any gaps and ensure all controls are captured. To be completed by 28 February 2019. • A protocol has been developed to monitor and alert phone coverage concerns and will remain in place until a review is undertaken and any alternatives are explored and implemented. Completed. • Universal risk assessments for infection control, restraints, and behaviors that challenge will be implemented by the clinical team in the service with the support of the Regional Clinical Partner, in line with Cheshire Ireland National Risk Management Plan. In order to ensure oversight any recommendations will be implemented and monitored by the PIC. To be completed by 28 February 2019. • The Regional Clinical Partner will conduct a review of the universal clinical risks in the service to identify any other areas that require risk assessment. In order to ensure	

oversight any recommendations will be implemented and monitored by the PIC. To be completed by 28 February 2019.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Emergency Response have been contacted to attend the service and in consultation with Cheshire Ireland National Health, Safety and Risk Manager will review the phone alarm alert system and the risk assessment and controls re same. To be completed by 28 February 2019. • A protocol has been developed to monitor and alert phone coverage concerns and will remain in place until review and alternatives are explored and implemented. Completed.	

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • Each month a regulated pharmacist conducts a stock control audit of all meds, including PRN count, to determine how much should be ordered for the next month. A record of these stock checks will be kept in the service. Completed. • A system of service led medication stock control will be implemented by 28 February 2019.	

Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: A Business case was submitted to HSE in May 2018 in relation to the required social supports and clinical needs. The PIC, Regional Manager, and Head of Operations are scheduled to meet with HSE on March 4th 2019 to discuss the additional clinical and social requirements outlined in the business case. • The HSE have been requested to fund private allied health care supports in the absence of HSE community based services.	

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The current risk assessment has been reviewed by the PIC and any required changes have been implemented. Completed.

• Emergency Response have been contacted to attend the service to change the alert system that is in place for one person to go directly to the staff call system. To be completed by February 28, 2019.

• Upon upgrade of the alarm system the risk assessment will be updated and monitored by the PIC to reflect the changes. To be completed by February 28th 2019.

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 15(1)	The registered provider shall 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.	Not Compliant	Orange	31/03/2019
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.	Substantially Compliant	Yellow	28/02/2019
Regulation 28(3)(b)	The registered provider shall	Substantially Compliant	Yellow	28/02/2019

	make adequate arrangements for giving warning of fires.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has 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.	Substantially Compliant	Yellow	28/02/2019
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	31/03/2019
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	28/02/2019