

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003445
Centre county:	Galway
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	Lorraine Egan (Days 1 & 2); Philip Daughen (Day 3)
Type of inspection	Announced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	1

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 announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
18 August 2015 12:00	18 August 2015 19:30
19 August 2015 10:00	19 August 2015 20:00
24 August 2015 11:00	24 August 2015 16:30

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 03: Family and personal relationships and links with the community
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 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This report sets out the findings of a registration inspection for Galway Cheshire House. Previously in July 2015 a registration inspection was commenced however, due to significant concerns raised by residents and staff in relation to safeguarding and safety of residents, the registration inspection was suspended and a focused inspection relating to safeguarding and safety was carried out.

During this registration inspection inspectors reviewed all 18 outcomes and followed up on actions arising from the last inspection. Residents spoken with said 'things had

improved'. One resident who had expressed considerable frustration on the previous inspection, told inspectors that they had met with the provider nominee and had their issue resolved. The resident received written confirmation that the issue would be addressed within a specified time frame.

While some measures had been taken by the provider to address safeguarding and safety of residents, staff working in the centre had not received refresher training in safeguarding of vulnerable adults since the previous inspection. Equally residents themselves had not received training or guidance on their rights or training in safeguarding to protect them. Inspectors were not assured by the responses from the provider, person in charge or regional manager that abuse would not go unreported again. They had not established why allegations of abuse had not been reported to them. Therefore, inspectors were not assured abuse prevention and management was robustly managed in the centre. Outcome 8; Safeguarding & Safety met with Major non compliance.

On this inspection there had been no real measurable progress made to address the number of non compliances found in Outcome 14; Governance & Management. Therefore, the non compliances found on the previous inspection were still relevant to the findings on this inspection. The number of non compliances still not addressed adequately were as follows:

- management structures in the centre were clearly defined for staff working directly for the organisation but were not clear for staff that were not. While the provider had addressed actions related to this in a previous inspection (October 2014), inspectors were still not satisfied they robustly addressed the non compliance.
- There were inadequate supervision and management systems in place which had direct negative impacts on residents. The person in charge was not adequately supported by the governance structures for the centre.
- The provider had yet to complete a report of the review of the safety and quality of the service as required by Regulations.
- There was no system of reviewing the quality and safety of the service provided to residents in the designated centre.
- Improvement was required to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Inspectors were not satisfied that arrangements in the absence of the person in charge robustly ensured adequate governance systems for the centre. There was no system whereby a senior member of staff assumed responsibility of the centre in the person in charge's absence.

A fire safety survey of the premises was carried out by an external fire consultant and actions were required to ensure the premises was safe for residents however, one month after the report had been given to the provider no actions had been completed. Inspectors were concerned also that a night time fire drill which was

requested as an immediate action on the previous inspection July 2015 had not been adequately carried out and had occurred at 7.15pm. Inspectors requested assurances and issued an action that a night time fire drill be carried out the night of the second day of inspection. This drill took place. However, inspectors were still concerned in relation to fire safety and management in the centre which resulted in a single issue inspection focused on fire safety and precaution carried out on the third day the findings of which are set out in Outcome 7 of the report with associated actions.

Health care systems were not robust and there were a number of health risks to residents that required addressing through comprehensive assessment and care planning with staff skilled to carry out recommendations.

From all 18 Outcomes reviewed on this inspection, two met with compliance. Major non compliance was found in Outcome 5; Social Care Needs, Outcome 7; Health & Safety & Risk Management, Outcome 8: Safeguarding & Safety and Outcome 14; Governance and Management. Other outcomes met with Moderate non compliance and one with substantial compliance.

The findings of this inspection are set out in the body of the report with associated actions.

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):

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

Findings:

Not all aspects of this outcome were reviewed on this inspection, the aspects not reviewed were reviewed during the previous inspection carried out 8 and 9 July 2015 and a number of non compliances were identified. These related to inadequate complaints management, policies and procedures. A lack of meaningful and documented consultation of residents' wishes and preferences in relation to the running of the centre and the service they received. Residents had also complained to inspectors that they were treated in a disrespectful manner by a small number of staff supporting them.

Since the previous inspection, the provider had initiated an investigation into complaints made by residents that some staff were disrespectful to them. The investigation was ongoing at the time of this inspection. Some residents spoken with told inspectors 'things had improved'. A resident, who had presented with distress and frustration during the previous inspection, said they were much happier now as their issue was being addressed and they had received written confirmation.

Inspectors reviewed some actions taken by the person in charge and provider that had been introduced since the previous inspection relating to complaints management. Inspectors noted improvements had occurred however; inspectors formed a view that the improvements were not robust enough to address the non compliances found.

Inspectors were not satisfied the complaints procedures met the matters as set out in the regulations. The complaints procedure for the centre was not centre specific, it did not outline who the nominated person was for the centre or who the nominated person

independent of the person nominated to deal with complaints was.

The complaints procedure was not in a format appropriate to the nature of some residents' disabilities some residents had visual impairments other residents were confined to bed most of the time or could not leave their apartment independently. Not all visitors to the centre, such as family members, entered the centre via the corridor which displayed the procedure. Therefore, though it was prominently displayed in one area it was not in other areas.

The Authority and contact details were documented in the complaints procedure which was incorrect as the Authority do not directly deal with complaints. The procedure also identified the regional manager (PPIM) and provider nominee as people outside the centre who could be contacted as part of an independent appeals process. Therefore the appeals process was not objective as both contacts were not independent of the centre.

An inspector reviewed the management of residents' finances. An organisational policy on money management had been drafted in April 2014. The policy set out that all residents receive a money management questionnaire and evaluation to ascertain the level of support they would require. From these assessments money management goals were set. This is further discussed in Outcome 5, Social Care Needs.

While systems were in place to keep monies safe through appropriate practices and record keeping, such as maintaining ledgers and receipts for expenditures or withdrawals of money. Inspectors were not satisfied that residents' monies and possessions were adequately safeguarded and secure in the centre. This is further discussed in Outcome 7 and 8.

Residents' residential units were individualised and personalised in some instances, but not all.

Inspectors found the overall provision of activities for residents required improvement. During the inspection, a number of residents went to day services, work or on trips to the community. However, a small number of residents also remained in the centre during the day and did not engage in any activities or meaningful engagement. Some residents were observed watching TV all day long, such as their physical disability they could not engage in independent activity or engagement. There was no documented social care plan for those residents to meet their specific needs.

Residents' living quarters were located to the back of the centre. A sign indicating visitors were entering a private area was located on a wall just before residents' living quarters. This had been put in place to address an action given on the October 2014 inspection. However, this was the only signage or indicator to notify visitors to the centre they should not enter residents' private living quarters. Residents' living quarters were not adequately distinguished from the rest of the building to ensure their privacy.

Judgment:

Non Compliant - Moderate

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Outcome 02: Communication <i>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.</i>
Theme: Individualised Supports and Care
Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.
Findings: All residents living in the centre could communicate independently. Each resident had their own unique communication style. Residents that required some specific communication supports had access to them, for example, one resident used a scanner to read written text. Televisions and radios were also available for residents to use in the centre. Other residents had assistive technology which allowed them call for assistance. However, the organisation did not have a communication policy as required in Schedule 5 of the regulations. An action for this is given in Outcome 18, Records & Documentation.
Judgment: Compliant

Outcome 03: Family and personal relationships and links with the community <i>Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.</i>
Theme: Individualised Supports and Care
Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.
Findings: All residents had links with their local community. Some residents had lived in the residential setting for many years and had a presence in the locality, for example, residents regularly visited the nearby shops, cafes and restaurants. Visiting was unrestricted and encouraged. Some residents visited their friends and family outside of the centre.

In an effort to integrate the centre into the community, the communal day room was available for local community groups to rent. However, the classes held in the room were not suitable for residents to join in with. Classes carried out in the centre were 'Mother and Baby' classes and 'Pregnancy Yoga'. A resident spoken with said if there were other classes such as cards or learning a musical instrument they would join in. At the time of inspection the communal day room was out of bounds to residents during class times.

When reviewing residents files inspectors found that one resident's 'fundamental and pressing needs' had been identified and documented through a 'person centred assessment' which was carried out between 2013 and 2014. One of the needs identified for a resident was to 're-establish relationships with some of their family'. However, the resident's personal plan in relation to this was not reflective of the identified need. The resident's personal plan set out that they would be supported to 'maintain relationships with their family'. This was not the need identified for the resident which was to 're-establish relationships'.

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):

No actions were required from the previous inspection.

Findings:

All residents had a contract of care which dealt with the support, care and welfare of the resident. It included details of the services to be provided for that resident. There was evidence of pre-assessments and a trial period before residents decided they wished to live in the centre.

All residents also had a tenancy agreement however, some did not outline the agreed rent fee, for example. Other tenancy agreements were not signed. Others had been signed by a family member. In those instances it was not clear if the resident had been consulted about the tenancy arrangements and fees charged to them.

Judgment:

Non Compliant - Moderate

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:

Residents social care needs were met in some parts but improvements were required to the overall assessment process and development of personal plans for each resident. Improvements were also identified to ensure all residents had opportunities to participate in meaningful activities appropriate to their interests.

The assessment of needs for residents was based on outcomes from a 'best possible health' assessment. The assessment did not adequately assess residents' social care needs. This non compliance was found on a previous monitoring inspection in October 2014. An action had been given which inspectors found had not been addressed adequately on this inspection.

Some residents had received a person centred planning assessment in 2013 to 2014. However, the outcomes from these assessments were not used to create social care plans for residents. This is further outlined in Outcome 3 relating to a resident's goal to re-establish family connections.

Of the plans reviewed none identified who was responsible for supporting residents to achieve goals, ascertain how effective the plans were or identify if the goals were achieved. Old plans had a line drawn through them, a date and a signature. This did not indicate if a goal was achieved or why the plan was discontinued.

Residents were not provided with copies of their personal plans in an accessible format. All aspects of residents' personal plans were kept in the office of which a code was required to access it.

There was little or no evidence to indicate there was a focus on maximising residents' personal development and/or life skills. Residents living in the centre had not received any training in food hygiene, rights or client protection, for example.

Inspectors were informed that some residents' spouses or family members were very

involved in aspects of their lives, for example, management of residents' personal finances. However, there was no documentation to indicate resident's families or next of kin had attended personal planning meetings or were involved with decisions relating to residents lives. Personal plans outlined various assessments and care plans but it was not clear if residents or their families, for example had been part of the creation of the plans or identification of goals.

One evaluation carried out in April 2015 identified a resident as wanting more independence around decisions relating to management of their money. It was also identified they would like to do shopping with their personal assistant during the week and set up a direct debit. None of these money management goals had been implemented.

Judgment:

Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

The location, design and layout of the centre was suitable to meet some of the needs of residents as set out in their personal plans and statement of purpose. However, the centre lacked a homely atmosphere, decor was dated throughout and there was a lack of communal spaces for residents to engage in cultural, social and religious activities if they wished to do so. Storage space was limited in some apartments.

The external premises were adequately maintained. They appeared clean with no visible hazards.

There were adequate laundry facilities within the centre. It was supplied with a washing machine and dryer. There were suitable arrangements for the safe disposal of general and clinical waste when required.

Overall, inspectors found the centre was not a homely environment. Inside the entrance to the centre were a number of offices to the left and right. One office space was rented out to an external agency and was not accessible to Galway Cheshire staff. A large communal day room was located just after the offices. This was not an inviting space. It

smelt musty. There were no home comforts in the space. It stored an altar, physiotherapy balls, Christmas decorations and folded up tables. The communal day room was not used by residents in any meaningful way. It was not inviting and did not provide residents with a space they could use for recreational, social or cultural gatherings.

Some residents required assistive equipment for their mobility needs, these included hoists, electronic chairs and specialised seating. While inspectors were encouraged to see residents' had their own personal equipment located in their residence, in some instances they took up room and were sometimes stored in residents' toilet/shower rooms. This is further discussed in Outcome 7.

There was a varying standard of cleanliness and decor from one residential unit to another, some appeared visibly cleaner than others.. Paint work in some needed updating and some features were not well maintained. The window blinds in one resident's 'apartment' were broken, paint on a wall in their residence had been touched up but the paint didn't match and looked unsightly and lacked attention to detail. The floor of another residence was not clean and the resident living there told an inspector, 'they would like to get the floor cleaned and they would do it themselves if they were able'.

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:

During the previous inspection in July 2015, there were significant risks identified in this outcome some of which required immediate action to address. They related to risk of injury from smoking and lack of fire drills. Other non compliances found related to infection control, health & safety and security risks.

Infection control issues had been found on the previous inspection in relation to pest control. Since the previous inspection the centre had set up a contract with a pest control company and measures were in place at the time of the inspection. However, further improvements were required in relation to infection control to ensure there were robust measures in place.

There was no scheduled cleaning regimen for equipment used by residents, for example, cleaning of residents' beds, wheelchairs, hoists and slings. Some residents spent long times in their beds or wheelchairs and to ensure best practice infection control practices this needed to be addressed.

There was now an up to date Health & Safety Statement for the centre which had not been in place on the July 2015 inspection.

All residents spoken with during the course of the previous July 2015 inspection highlighted their concerns in relation to the inadequate security of the doors to their apartments. They were all concerned that they were not secure and could be easily opened by an intruder which they informed inspectors worried them. This risk had been identified by the HSO during their audit of the centre in the days prior to the inspection. The inspector reviewed the entry and exits to residents' apartments and also had concerns that they were not secure and therefore residents were at risk.

The provider had fitted some window restrictors as a security measure in the interim before a schedule of works would be carried out to address security issues. At the time of inspection the works had not begun but were scheduled to commence the 31 August 2015. In the meantime security in the centre remained a risk and an aspect of this is further discussed in Outcome 8.

In relation to fire drills they had occurred in February and June 2015 but had occurred during fire training and there had been no drills outside of these times to ensure staff could carry out a response to a fire without a qualified instructor. There had also been no night time drills. This required review and an immediate action was issued during the last inspection for this to be addressed.

On this inspection, an inspector reviewed two fire drills that had been carried out. One had occurred during the daytime on 22 July, the other drill was a night time drill which was carried out on the 15 July 2015 at 7.15pm. While attempts had been made to replicate conditions for night time using similar staffing levels that would be allocated at night, inspectors were not satisfied this drill had addressed the immediate action given and sought more assurances.

Inspectors requested a night time drill to occur the night of the second day of inspection, 19 August 2015. A drill was carried out on the night of the 19 August at 23.10pm, 1hr.10mins after night medications were administered. The drill took in total approximately 15minutes.

On the previous July 2015 inspection a significant risk was identified in relation to a resident that smoked and required specific supports and supervision. On the previous inspection, the inspector had identified significant concerns for a resident which required immediate actions in relation to fire risk and also safeguarding and safety. The action plan response to the immediate action was reviewed on this inspection. Risk control measures had been reviewed and updated to include more robust supervision practices. The resident continued to use a fire blanket to prevent smoking related injuries.

A fire safety assessment report was carried out of the designated centre by an external

fire consultant. This was initiated by the provider. A number of fire safety non compliances were found during the survey with an associated risk rating. One of the works recommended was the compartmentalisation of the attic space which would prevent the unseen spread of fire to other parts of the building. This would take a considered amount of time for those works to be addressed.

However, other works that were required to be completed, based on the report included, painting of overhead joists in the communal day room, replacing seals on doors and ironmongery works all of which could be completed in a relatively short space of time. At the time of inspection, the provider had put the works out to tender and had received two costings and were waiting for a third before commencing works.

Subsequently, based on the findings of the inspection in relation to fire safety the Authority carried out an unannounced single issue inspection in relation to fire safety and precautions. This occurred on the 24 August and the findings of this are outlined below.

The inspector found the building to be a single storey structure built approximately twenty years ago. The building was noted as being of traditional masonry construction with a plasterboard ceiling and a tiled roof supported on timber rafters. The building was divided in to two general areas. The first area contained office accommodation as well as communal space, storage and staff facilities including a staff bedroom. The second area consisted of residential accommodation in the form of self contained bedsit type apartments with access directly from the outside as well as through a communal internal corridor. This area also contained sluice, laundry, physiotherapy, storage and office facilities.

The inspector found that generally, the building had been provided with an adequate number of escape routes. The final exit doors on these escape routes were noted as being openable in the direction of escape without the use of a key. It was noted that some internal doors, such as the alternative exit doors from the apartments in to the link corridors required the use of a key which could represent an unnecessary delay in the event of an evacuation using this route.

The inspector found the building to be provided with first aid fire fighting equipment throughout. They also noted the presence of a fire alarm system in the building. The panel for this was located by the main entrance along with instructions on how to deduce the location of the activation from the panel. Inspectors noted that emergency lighting had been installed in the building although some areas were noted as not being provided with emergency lighting, in particular the residential accommodation and the areas outside final exits from the building.

The inspector found that the provision of fire resistant construction throughout to protect means of escape and contain fire within the building was inadequate. None of the doors provided internally as fire doors were equipped with cold smoke seals to prevent the passage of smoke throughout the building. A number of the doors, including the door to the laundry room which was in itself a room of fire risk, were provided with self closing devices that were not capable of closing the door fully thus compromising their function as fire doors. The inspector noted instances where services penetrated

ceilings and were not fire stopped appropriately to prevent the movement of heat and smoke throughout the building. The roof space above the bedrooms was observed as not being subdivided as appropriate with fire resistant construction to prevent the unseen spread of fire and smoke through the building.

Each apartment was noted as being provided with electric cooking equipment and electric storage heating. Each apartment was noted as being provided with a fire blanket and extinguisher adjacent to the cooker. Each apartment was noted as having individual electrical distribution boards. One of these was checked by the inspector and was found to be fitted with a residual current device for the safety of the resident.

The rest of the centre was heated by a gas boiler located in a boiler house accessed from the outside of the building.

Upon checking maintenance records, the inspector found a programme of daily and weekly fire safety checks. However, the inspector noted that the daily checks had not been recorded as completed on the two days prior to the inspection. The inspector also noted that the most recent scheduled weekly check had not been recorded as completed. The schedule of checks were examined by the inspector and found to be inadequate due to their generic nature. The checks took no account of site specific arrangements. There was nothing on the daily or weekly schedule relating to control measures put in place to reduce the risk of fire for individual residents. The inspector also noted there were no adequate checks in place to prevent the accumulation of lint in clothes dryers, which was observed on inspection.

The inspector found that the maintenance records relating to the fire alarm system and emergency lighting were inconsistent. The inspector was informed by the person in charge that maintenance on these systems was carried out periodically although the inspector was unable to confirm this through reference to the records present in the centre. The inspector did find that the first aid fire fighting equipment was maintained as required.

Upon examination of the fire procedure, the inspector found it to be generic in nature and took no account of the site specific evacuation procedures to be followed in the event of fire within the centre. The procedure took no account of the preferred escape route from the residential accommodation and made no mention as to how and what was required in order to utilise same. The inspector found that additional safeguards were required in order to ensure that the primary escape routes from the apartments were accessible by staff at all times to facilitate evacuation of residents.

The inspector noted that personal evacuation plans had been created for the residents. These contained useful information on evacuation considerations of residents although more information was required in some as to exactly how the resident was to be evacuated and with what evacuation aids in the event of an evacuation, both at night and during the day.

The inspector examined fire drill records relating to fire drills carried out on foot of the previous inspection. While the records contained a satisfactory level of detail, they also did not assure the inspector that the staff were aware of the procedures to be followed

in the event of fire and that the evacuation of the centre could be carried out in a suitably timely fashion at all times in the event of a fire. The fire drill records identified issues relating to the use of appropriate evacuation techniques and aids. Many of the evacuations were noted as being carried out with the use of a hoist as opposed to through the use of the evacuation aids. It was however, noted from examination of the records and discussions with the person in charge that areas requiring improvement had been identified and were in the process of being addressed in many cases.

On this inspection, the inspector found that residents who wished to smoke were facilitated to do so and appropriate control measures had been put in place to facilitate the residents preferences safely. These control measures had been identified and reviewed as part of on-going risk assessment and failings identified on previous inspection. The control measures were observed as being in place when necessary during the course of the inspection.

The inspector was supplied details during the inspection as to a programme of remedial works to be implemented in order to rectify the fire safety deficiencies within the building. These were not found to be supplied with a timescale but the inspector was verbally informed by management that the works were to begin on Monday 31st August and were estimated to take one month to complete. Upon examination of the breakdown of the works, the inspector found that if completed it would address the majority of the building related fire safety deficiencies The inspector did note however, that works related to the upgrading of existing double doors, door fastenings to bedroom doors, and emergency lighting installation were not included within the document.

The inspector was also informed at the conclusion of the inspection that the person in charge was going to make immediate arrangements for staff to receive further training in the use of evacuation aids to ensure all staff are fully aware as to the use of appropriate evacuation techniques in the event of an evacuation of the centre.

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:

During the previous July 2015 inspection, inspectors had a number of concerns in relation to safeguarding and safety of residents in this centre this was in part due to the practices supporting some residents to smoke which put them at serious risk of fire related injuries and also in relation to residents alleging a small number of staff were disrespectful to them.

As mentioned in Outcome 7 an immediate action was given in relation to risks identified for a resident who smoked. A further immediate action was given by inspectors to ensure the provider investigated this practice under safeguarding also. Another immediate action was also given under safeguarding & safety in relation to residents' allegations that a small number of staff were disrespectful to them.

Inspectors reviewed action plan responses by the provider and person in charge. Since the previous inspection the person in charge had met with all residents and consulted with them in relation to the service they were receiving and if they had any concerns.

The provider had acquired the services of an external consultant to commence an investigation into allegations of neglect and omission. At the time of inspection, two staff had been suspended without prejudice as the investigation was underway.

A number of interviews were carried out during the inspection with the person in charge, the regional area manager and the provider nominee. From the responses to questions relating to safeguarding and safety during the interviews, inspectors were not assured that there were sufficiently robust safeguarding measures in place at the time of inspection. Inspectors were not assured that adequate measures had been implemented to ensure incidents of alleged abuse would not go unreported again.

Staff had not received updated safeguarding and safety training since the previous inspection to ensure they had up to date comprehensive knowledge of client protection. Residents in the centre had not received training and knowledge of their rights and safeguarding issues. Training of this nature which would give them the skills and insight to identify incidents of abuse and bring them to the attention of the person in charge, for example.

At the time of inspection Galway Cheshire had no policy for the provision of behavioural support and action in relation to this is given in Outcome 18, Records & Documentation.

Judgment:

Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

A record of all incidents occurring in the centre was maintained and where necessary notified to the Chief Inspector. The inspector reviewed incidents and accidents documented in the centre and found that most incidents requiring notification had been submitted to the Authority as per the regulations.

However, the Authority had not received notification in relation to incidents of misconduct as required by the regulations, at the time of inspection there were ongoing investigations in relation to alleged misconduct. This was brought to the attention of the person in charge who agreed to submit the relevant notifications to the Chief Inspector.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

Residents' educational/employment/training goals were supported for those who had greater independence and mobility than other residents in the centre.

Some resident were very independent and were assisted to attend work and training courses outside of the centre. However, there was inadequate assessment of residents' education and employment needs for any resident in the centre.

Residents with greater dependency needs, for example, were not engaged in any meaningful process which would enhance their general welfare and development.

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):

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

Findings:

Resident's health needs were met to some extent however, significant improvement was necessary in relation to healthcare assessment, care planning and assisting residents to achieve optimum health.

On a previous monitoring inspection October 2014 an action was given in relation to lack of nursing care provision for residents living in the centre. At the time residents were provided with 10 hours nursing care per week which was not spread over the course of seven days. This had raised concern with the inspector that significant healthcare needs of some residents were not being met. The provider responded to the October 2014, action by increasing the number of nursing care provision to 20 hours over seven days.

However, having reviewed a sample of health care plans for residents inspectors found some healthcare risks were still not adequately assessed or managed such as, nutritional risk assessments, pressure ulcer prevention, health checks and dental health.

Residents' nutritional risk was not monitored consistently. Residents' nutritional risk had been calculated using a recognised nutritional risk assessment. However, ongoing review was not evident as their nutrition risk score was only calculated once in all sample care plans reviewed. Residents' weights were not assessed regularly. Each care plan reviewed indicated their weight had been documented and used to calculate their body mass index (BMI) and nutritional risk but this had only occurred once.

Some residents were identified as being high risk of developing pressure ulcers. This had been assessed using a recognised assessment tool. However, a care plan to prevent a resident identified at high risk of developing an ulcer was inadequate to mitigate the risk. The care plan set out that the resident used a pressure relieving electric mattress at all times. Staff were to check the mattress was working each morning. However, staff spoken with informed an inspector they did not know how to check the mattress and if there was a fault they would ring the maintenance company. The inspector checked the mattress which was set at 95kgs. However, the resident's weight was documented as 78kgs. The inspector was unable to ascertain from staff if the mattress setting was correct or not. This presented as a risk to the resident, if the setting was incorrect this could lead to the resident developing pressure ulcers.

Some residents in the centre had pressure ulcers which were managed using protective dressings to prevent further breakdown. However, there were no associated care plans in place outlining how wound healing was being assessed or to ascertain if there was an improvement or deterioration.

Residents were reviewed and assessed by allied health professionals skilled in speech and language therapy, nutrition, physiotherapy and occupational therapy. Their assessments and notes were detailed and recommendations made were based on assessments made. However, associated care plan of which staff should follow in order to carry out health care recommendations were not in place.

Residents had not received an annual health check.

Residents' dental appointments were not documented in health care plans. Inspectors were not adequately assured that residents were supported to attend preventative dental health checks that they were entitled to receive.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Residents were protected by the designated centre's policies and procedures for medication management in the most part however; there was no self administration of medication policy in place at the time of inspection.

The policies in relation to medication management, which had been reviewed in August 2014, were made available to inspectors. The policies covered ordering, receipt, prescribing, storage, administration and disposal of medicines. Policies were also available to staff online.

Medicines were supplied by a local community pharmacy on a weekly basis. There had been a recent change to the pharmacy provider and the person in charge confirmed the service provided was satisfactory.

An inspector that reviewed management of medication noted that all medications were stored securely on the two days of inspection.

Medication management training was completed by all staff March 2014.

Where a resident required medications to be administered via a gastrostomy tube, alternative dosage forms had been considered such as liquids. Where it was deemed necessary, the prescriber had identified the need for crushing on each individual prescription.

On the previous inspection, July 2015, there had been a number of medication errors documented, whereby tablets were found in a resident's apartment on the floor, for example.

The person in charge outlined that this issue had been resolved. A resident who self administered medication was re-assessed by the person in charge as requiring some added supports. They had established a management process to mitigate risks by giving the resident their medications each day rather than a weekly supply. This had worked successfully. The inspector noted there were less medication errors on this inspection.

However, there was no self administration of medication policy available for the inspector to review on the inspection. This required review. An action relating to this is given in Outcome 18; Records & Documentation.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a written statement of purpose that described the service provided in the centre.

The services and facilities outlined in the Statement of Purpose, and the manner in which care was provided, reflected the diverse needs of residents.

However, the statement of purpose did not provide an adequate description of the size and layout of residents' 'studio apartments' as documented in the Statement of Purpose.

Judgment:

Substantially 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:

A number of actions were given in this outcome on the previous inspection July 2015. On this inspection there had been no real measurable progress made to address the number of non compliances found on the previous inspection. Therefore, the non compliances found on the previous inspection were still relevant to the findings on this inspection.

The number of non compliances still not addressed adequately were as follows:

- management structures in the centre were clearly defined for staff working directly for the organisation but were not clear for staff that were not. While the provider had addressed actions related to this in a previous inspection, inspectors were still not satisfied they robustly addressed the non compliance.
- there were inadequate supervision and management systems in place which had direct negative impacts on residents. The person in charge was not adequately supported by the governance structures for the centre.
- the provider had yet to complete a report of the review of the safety and quality of the service as required by Regulations.
- there was no system of reviewing the quality and safety of the service provided to residents in the designated centre.
- improvement was required to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Inspectors were not satisfied that arrangements in the absence of the person in charge robustly ensured adequate governance systems for the centre. There was no system

whereby a senior member of staff assumed responsibility of the centre in the person in charge's absence.

An inspector spoke with some staff in relation to how things were since the previous inspection. The inspector was concerned that staff described their morale was low and since the previous inspection the staff team had identified some team members as 'whistleblowers'.

The inspector was not assured that staff could raise concerns about the quality and safety of care in the centre without reprisals.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The provider was aware of their regulatory responsibility to notify the Chief Inspector of the absence of the person in charge for more than 28 days.

The regional area manager acted as person in charge in their absence however, during those times they were not located in the centre and had a remit whereby they travelled to other Cheshire centres throughout the North West of the country. While the PPIM demonstrated knowledge of the running of the centre. Inspectors were not satisfied that this arrangement robustly ensured adequate governance systems for the centre in the person in charge's absence.

There was no system whereby a senior member of staff assumed responsibility of the centre in the person in charge's absence either.

While this outcome meets with compliance an action is given in Outcome 14; Governance & Management in relation to this.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The centre was adequately resourced to meet the needs of residents in relation to staffing numbers on duty at any given time. The provider had arranged for an increase nursing care provision hours for in the centre which had commenced in July 2015.

However, there was no weighing scales in the centre. A number of residents had significant mobility issues which would require specialist weighing scale equipment. This was not available and there was evidence to indicate residents were not weighed regularly to monitor for nutritional risk.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

There were adequate staffing numbers to meet the needs of residents during both days of inspection. However, there were a number of non compliances found in this outcome which required addressing.

Staff had not received up to date client protection training since the previous inspection. The provider outlined the training was given by a designated person within the organisation and carried out every three years. The training was carried out over a

couple of hours. However, the provider or PPIM could not outline to inspectors what qualifications the trainer had to carry out client protection training to staff. The provider was required to review training given to staff on client protection and abuse.

Staff working in the centre were not able to operate electronic mattresses used in the centre to ensure they were kept at the correct setting for the resident.

Not all staff had received training in food hygiene despite being engaged in the preparation of resident meals on a regular basis.

While the provider had increased the nursing care provision for the centre, inspectors were not satisfied that they adequately provided for the nursing care needs of residents as evidenced in health care planning.

A sample of staffing records were reviewed as part of this outcome. Of the sample reviewed none met the requirements of the regulations as set out in Schedule 2.

- one file did not have a full employment history, adequate references or a job description.
- one file did not have a job description, any employment history or Curriculum Vitae (CV).
- one file did not have an employment history.

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):

No actions were required from the previous inspection.

Findings:

Not all schedule 5 policies were in place at the time of inspection.

There was no organisational policy for admissions, including transfers, discharge and the

temporary absence of residents, provision of behavioural support and communication with residents.

There was no self administration of medication policy available for the inspector to review on the inspection.

While staff had access to policies for the organisation 'online', schedule 5 policies were not readily accessible in the centre in any other format.

There was no formal system to ensure staff had read and had an understanding of policies in place. Some hard copy policies available in the centre had been signed by some staff that they had read and understood them but in some instances only three staff signatures were documented.

A directory of residents was maintained but online and did not contain all the matters as set in the Regulations.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ann-Marie O'Neill
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 report¹

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003445
Date of Inspection:	18 August 2015
Date of response:	22 October 2015

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:

Residents' living quarters were not adequately distinguished from the rest of the building to ensure their privacy.

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:

a)The private residential area of the designated centre will be re-painted and re-decorated to ensure it is visually different from the public area of the building.

b)Signage will be revised and amended to ensure it is more evident to individuals. Additional signage will also be sourced and displayed in a prominent manner.

c)A redecorated communal room will be provided for use by residents as they wish and the current provision of the room for external groups will be limited. This will significantly reduce the numbers of external visitors to the building

Proposed Timescale: a)31st October 2015 b) 31st October 2015 c) 30th November 2015

Proposed Timescale: 30/11/2015

Theme: Individualised Supports and Care

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

Residents' residential units were individualised and personalised in some instances, but not all.

2. 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.

Please state the actions you have taken or are planning to take:

a)All residents have been consulted with around the re-decoration, style and colour of their units. Work is being carried out in line with their expressed wishes and individuals will be supported to individualise their unit with personal effects.

Proposed Timescale: 31/10/2015

Theme: Individualised Supports and Care

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

Inspectors found the overall provision of activities for residents required improvement. During the inspection, a number of residents went to day services, work or on trips to the community. However, a small number of residents also remained in the centre during the day. They did not engage in any activities or meaningful engagement.

3. Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:

a) Individual Plans will be developed, with residents leading the development of these plans. These plans will include individual's wishes with regard to their activities & interests, relationships and goals. These plans will be developed by the Social Supports Facilitator and reviewed 6 weekly to evaluate & measure for effectiveness. Support will be provided by Cheshire Ireland staff to ensure these wishes and goals are progressed and / or achieved.

b) A redecorated communal room will be provided for use by residents as they wish and the current provision of the room for external groups will be limited. Consultation will be held with residents as to the facilities to be provided in the room

Proposed Timescale: Proposed Timescale: a) 30th November 2015. b) 30th November 2015

Proposed Timescale: 30/11/2015

Theme: Individualised Supports and Care

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

The complaints procedure did not outline who the nominated person was for the centre.

4. Action Required:

Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

Please state the actions you have taken or are planning to take:

a) Internal information regarding the Complaints Procedure has been revised and now includes the name and contact details of the person nominated within the centre for individuals to contact if they have a complaint / concern. Information is displayed in a number of areas within the designated centre.

Proposed Timescale: a) 21st August 2015 completed

Proposed Timescale: 21/08/2015

Theme: Individualised Supports and Care

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

The complaints procedure for the centre did not identify who the nominated person, independent of the person nominated to deal with complaints were.

5. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:

a) Internal information regarding the Complaints Procedure has been revised and now includes the name and contact details of the person nominated, other than the person in charge, for individuals to contact if they have a complaint / concern. Information is displayed in a number of areas within the designated centre.

Proposed Timescale: : a) 21st August 2015 completed

Proposed Timescale: 21/08/2015

Theme: Individualised Supports and Care

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

The complaints procedure was placed on the notice board on the corridor to residents' apartments but it was not in a format appropriate to the nature of some residents' disabilities.

6. Action Required:

Under Regulation 34 (1) (a) you are required to: Ensure that the complaints procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:

a) Cheshire Ireland's National Learning and Development Manager have produced an audio version of the complaints procedure for residents who require this. This audio version currently being distributed and discussed with individuals by the Care Coordinator/Nurse as required.

b) An easy to read complaints poster in large format has been designed and placed in prominent areas within the building.

Proposed Timescale: a) Completed 1st October 2015 b) 15th October 2015

Proposed Timescale: 15/10/2015

Theme: Individualised Supports and Care

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

Not all visitors to the centre, such as family members, entered the centre via the corridor which displayed the procedure. Therefore, though it was prominently displayed in one area it was not in other areas.

7. Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:

a)An information pack is currently being developed for each resident & their family or friends. The pack will be available to each resident and will be stored by them in their apartment. With permission and where appropriate the pack will be reviewed with the resident and their family so as to ensure information is shared. The pack will include;

- Residents Guide
- Complaints Procedure
- Contact details for all individuals involved in the complaints process.
- Advocacy details & contacts.
- Confidential Informant details & contact details.

Proposed Timescale: 15/11/2015

Theme: Individualised Supports and Care

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

The Health Information & Quality Authority and contact details were documented in the complaints procedure which was incorrect as the Authority do not directly deal with complaints.

The procedure identified the regional manager (PPIM) and provider nominee as people outside the centre who could be contacted as part of an independent appeals process. Therefore the appeals process was not objective as both contacts were not independent of the centre.

8. 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 Complaints Procedure has been reviewed;

a)The Health Information & Quality Authority has been removed as a contact

b)An alternative employee of the service provider who does not work in the centre has been nominated as an independent contact.

Proposed Timescale: : a) , b) Completed 24th August 2015

Proposed Timescale: 24/08/2015

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

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

Classes held in the communal day room were not suitable for residents to join in with.

A resident's personal plan set out that they would be supported to 'maintain relationships with their family'. This was not the need identified for the resident which was to 're-establish relationships'.

9. Action Required:

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:

a)The use of the communal day room has been reviewed. The room will not be available for these classes from 31st October 2015. The room will be redecorated and refurbished to the wishes of the residents and made available for their use as a common recreational space.

b)Individual plans will be reviewed with residents to ensure they are updated and reflect current information. These plans will include individual's wishes with regard to their activities and interests, relationships and goals, These plans will be developed by the social supports facilitator and reviewed six-weekly to evaluate and measure for effectiveness. Support will be provided by Cheshire Ireland staff to ensure these wishes and goals are progressed and/or achieved.

Proposed Timescale: a)30th November 2015 b) 30th November 2015

Proposed Timescale: 30/11/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

All residents also had a tenancy agreement. However, some did not outline the agreed rent fee.

10. Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:

a) Tenancy agreements will be reviewed by the Person in Charge and Cheshire Ireland's Housing Officer and amended to include all fees payable. This review will be carried out with each resident and /or their family members / friends / advocate.

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

Not all tenancy agreements were signed. In some instances they had been signed by a family member. In those instances it was not clear if the resident had been consulted about the tenancy arrangements and fees charged to them.

11. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:

a) Tenancy Agreements will be reviewed by Person in Charge along with the Cheshire Ireland's Housing Officer and amended appropriately to include signature of the resident or their designate. This review will be carried out with each resident and / or their family members / friends/ advocate.

Proposed Timescale: 30/11/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

Residents were not provided with copies of their personal plans in an accessible format. All aspects of residents' personal plans were kept in the office of which a code was required to access it.

12. 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:

- a) Individual residents' plans will be stored in the residents' apartment and reviewed with each resident as they are updated (every 6 weeks or as required).
- b) A secured storage unit will be installed in each apartment for the storage of confidential material such as individual plans.

Proposed Timescale: a) 31st October 2015 b) 15th November 2015

Proposed Timescale: 15/11/2015

Theme: Effective Services

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

The assessment of needs for residents was based on outcomes from a 'best possible health' assessment. The assessment did not adequately assess residents' social care needs.

13. Action Required:

Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:

- a) The Service Provider has reviewed the Best Possible Health Assessment and is expanding it to include a section entitled "Interests & Activities" and another section entitled "Relationships & Personal Goals". This assessment will form the basis of the individual person Social Plan which will be monitored by the Social Supports Facilitator. Each resident will have an updated active Social Care Plan by 31st December 2015.

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

Some residents had received a person centred planning assessment in 2013 to 2014. However, the outcomes from these assessments were not used to create social care plans for residents.

14. 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:

a)The Service Provider has reviewed the Best Possible Health Assessment and is expanding it to include a section entitled "Interests & Activities" and another section entitled "Relationships & Personal Goals". This assessment will form the basis of the individual person Social Plan which will be monitored by the Social Supports Facilitator. Each resident will have an updated active Social Care Plan by 31st December 2015.

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

Of the plans reviewed none identified who was responsible for supporting residents to achieve goals, ascertain how effective the plans were or identify if the goals were achieved.

15. 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)The Service Provider has reviewed the Best Possible Health Assessment and is expanding it to include a section entitled "Interests & Activities" and another section entitled "Relationships & Personal Goals". This assessment will form the basis of the individual person Social Plan which will be monitored by the Social Supports Facilitator. Each resident will have an updated active Social Care Plan by 31st December 2015.

b)Plans will be specific, time framed and actioned to ensure they are measurable and effective. Each plan will be discussed at a 6 weekly review.

c)The Person in Charge will meet the Social Supports Facilitator monthly to review the progress of the individual plans.

Proposed Timescale: a), b) 30th November 2015, c) ongoing

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

Old plans had a line drawn through them, a date and a signature. This did not indicate if a goal was achieved or why the plan was discontinued.

16. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:

a) Previously when Care Plans were updated the old plan was stored in archive and a line drawn through as above so as to indicate it was no longer valid. A new care plan was developed and placed into the Active File holding updated information. The system was not sufficiently developed to capture changes & progressions. This has been reviewed and the new national system which captures changes has been developed. The new system will be implemented with all care plans.

b) The Regional Clinical Education Facilitator will hold a group information session with care staff regarding Cheshire Ireland's documentation requirements. The Person in Charge, Care Coordinator (Nurse) & Social Supports Facilitator will monitor all personal care plans on a regular basis and review each plan formally on a 6 weekly basis.

Proposed Timescale: a) 30th November 2015, b) 30th November 2015

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

There was little or no evidence to indicate there was a focus on maximising residents' personal development and/or life skills.

17. 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) The Service Provider has reviewed the Best Possible Health Assessment and is expanding it to include a section entitled "Interests & Activities" and another section entitled "Relationships & Personal Goals". This assessment will form the basis of the individual person's Social Plan which will be monitored by the Social Supports Facilitator. Each resident will have an updated active Social Care Plan by 31st December 2015.

b) Plans will be specific, time framed and actioned to ensure they are measurable and effective. Each plan will be discussed at a 6 weekly review meeting.
c) Cheshire Ireland's Service Quality Officer is developing a questionnaire which will be discussed with residents to glean information regarding the quality of the services provided to individuals living within Cheshire Ireland designated centres. This information will be analysed and utilised to improve the quality of services received by residents

Proposed Timescale: a), b) 30th November 2015, c) 30th November 2015

Proposed Timescale: 30/11/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Overall, inspectors found the centre was not a homely environment.

There was a varying standard of cleanliness and decor from one residential unit to another, some appeared visibly cleaner than others..

Paint work in some needed updating and some features were not well maintained

18. 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:

a) All residents will be met with to discuss their ideas and opinions regarding the service and its design and décor.

b) All residential units will be re-painted and re-decorated in line with the wishes of the individual residents.

c) Residents are offered an overall clean of their apartment on a weekly basis and a record of this will be maintained in the Cleaning Records.

Care staff have to date implemented a 'clean as you go' policy and will continue to monitor apartments on a daily basis. Care staff will provide light cleaning and household assistance as required. Where additional supports are required these will be referred to the Cleaner to be addressed.

d) The communal room will be re-decorated & refurbished in line with residents' wishes to ensure that it is an attractive recreational space for resident's use.

Proposed Timescale: a), b) 23rd October 2015 c) 21st August & ongoing, d) 30th November 2015

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

Some residents required assistive equipment for their mobility needs, these included hoists, electronic chairs and specialised seating. While inspectors were encouraged to see residents' had their own personal equipment located in their residence, in some instances they took up room and were sometimes stored in residents' toile/shower rooms

The communal day room was not used by residents in any meaningful way. It was not inviting and did not provide residents with a space they could use for recreational, social or cultural gatherings.

19. 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:

a) Storage options within the building are under review. Where possible items will be stored in agreement with residents outside of their residences or stored in the most efficient manner within their residence to create space.

b) The communal room will be re-decorated and re-furnished in line with residents wishes so as to be an attractive recreational space for their use. All residents will be met by the person in charge to discuss their ideas and opinions regarding the service and its design and décor.

Proposed Timescale: : a) 31st October b) 30th November 2015

Proposed Timescale: 30/11/2015

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:

The means of escape was not adequate in the following respects:

Not all doors on escape routes were openable in the direction of escape without the use of a key.

There was an absence of emergency lighting within the residential accommodation and

to the areas immediately adjacent to final exits.

The means of escape was not adequately protected with fire resistant construction and fire rated doors.

20. 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:

- a) All escape route doors are openable via thumb-turn and do not require a key. Panic bolt: push bar has been installed on all final exit doors in the Service.
- b) Emergency lighting has been installed in all apartments. Emergency lighting system in compliance with IS 3217 2013.
- c) Doors have been installed and are protected with the appropriate fire rating.

Proposed Timescale: a), b) c), completed 28th September

Proposed Timescale: 28/09/2015

Theme: Effective Services

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

The arrangements in place for the containing of fire were not adequate in the following respects:

The fire doors provided throughout were identified as not being able to adequately prevent the movement of fire and smoke throughout the building. The doors were not provided with appropriate cold smoke seals. Not all doors were not provided with adequate self closing devices.

Services were not fire stopped in all cases where they penetrated building elements to prevent the movement of heat and smoke throughout the building.

The roof space above the bedrooms was observed as not being subdivided as appropriate with fire resistant construction.

21. 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:

- a) New cold smoke seals have been installed on doors.
- b) Doors have been fitted with self-closing devices which are connected to the fire alarm and have automatic closure on activation of the alarm.

- c) Services have been fire stopped throughout the building.
- d) The roof space has been compartmentalised with appropriate fire resistance materials.

Proposed Timescale: a), b), c), d) completed 28th September.

Proposed Timescale: 28/09/2015

Theme: Effective Services

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

The daily and weekly fire safety checks in place had not been recorded as completed when required prior to the inspection of the centre.

The daily and weekly checks were generic in nature and took no account of site specific arrangements as detailed within the findings.

There records pertaining to the fire alarm and emergency lighting did not adequately demonstrate that maintenance was being carried out on same as required on an on-going basis.

22. 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) A staff member has been assigned to review fire check and ensure completion.
- b) Daily fire checks have been reviewed and are amended to include centre specific checks.
- c) Weekly fire checks are under review, this review is due for completion 16th October.
- d) All fire alarm and emergency lighting checks were complete at the time of the inspection. The Person in Charge has requested more comprehensive documentation for servicing of same from individual companies.

Proposed Timescale: a), b) d) Completed (28th September 2015, c) 16th October 2015

Proposed Timescale: 16/10/2015

Theme: Effective Services

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

The evacuation procedure was generic in nature and took no account of the preferred

escape route from the residential accommodation.

Additional safeguards were required in order to ensure that the primary escape routes from the apartments were accessible by staff at all times to facilitate evacuation of residents.

The personal evacuation plans did not contain sufficient detail as to the evacuation needs of the residents in all cases.

23. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:

- a) The evacuation procedure of the designated centre has been amended to be specific to the centre. New signage has been ordered to reflect these changes,
- b) Personal Emergency Evacuation Procedures are being reviewed for each resident following the installation of new doors and windows for each room.

Proposed Timescale: a) completed 30th September 2015 b) completed 12th October 2015

Proposed Timescale: 12/10/2015

Theme: Effective Services

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

The fire drill records did not demonstrate that staff were aware as to the correct procedure to follow in the event of fire and that an evacuation could be carried out in a timely fashion at all times within the centre.

24. Action Required:

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

Please state the actions you have taken or are planning to take:

- a) Fire Drills training exercise have been undertaken on 27th July and again on 19th August. This is ongoing in the service as part of fire safety and safety training. Following the completion of Fire safety upgrade to the building further drills are planned as below.
- b) Following fire safety upgrading to the building a daytime drill will take place on the 14th October 2015
- c) Following Fire Safety upgrading to the building a night time drill will take place by the 23rd October 2015.
- d) Fire Drills training exercises will continue monthly.

Proposed Timescale: a) ongoing b) Completed 14th October 2015 c) 23rd October 2015
d) ongoing 20th November, 11th December.

Proposed Timescale: 11/12/2015

Theme: Effective Services

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

The examination of fire drill records demonstrated that not all staff were aware as to the appropriate arrangements for the evacuation of residents from the centre.

25. 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:

- a) Fire Drills training exercise have been undertaken on 16th July 27th July and again on 19th August. This is ongoing in the service as part of fire safety and safety training.
- b) Following fire safety upgrading to the building a daytime drill took place by the 14th October 2015
- c) Following Fire Safety upgrading to the building a night time drill will take place by the 23rd October 2015 .

Proposed Timescale: a) 16th, 27th July, 19th August, 8th October, 14th October
Completed b) Completed 14th October 2015 c) 23rd October 2015

Proposed Timescale: 23/10/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Inspectors were not assured that adequate measures had been implemented to ensure incidents of abuse would not go unreported again.

From the responses to questions relating to safeguarding and safety during the interviews, inspectors were not assured that there were sufficiently robust safeguarding measures in place at the time of inspection.

26. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:

- a) A Human Rights Based Approach to Adult Protection and Safeguarding training session has been delivered to all staff 29th September 2015
- b) A Dignity at work information session has been delivered to staff 30th September 2015
- c) The Person in charge will meet all staff individually and review safeguarding and staff knowledge and responsibilities of same at each supervision session.
- d) All staff will receive individual supervision session at least on an 8 weekly basis.
- e) Safeguarding will be discussed and reviewed at staff team meetings.
- f) The North Western Regional Manager will make time to meet formally and informally with residents to ensure there is another person available to listen to feedback. Structured meetings with residents will take place on a quarterly basis.
- g) Adult Protection and safeguarding sessions on the rights of residents to be safe and protected in the centre will be held to ensure clarity regarding individual's rights and the responsibility of the Registered Provider.

- h) Monthly one-to-one meetings will be held by the Person in Charge with the residents and the group meetings will also be scheduled to consult with the residents if they so wish to attend.

- i) Each resident has been given information about the availability of local advocacy services and how to access them. This information can also be provided to them in written formats accessible to their individual support needs.

Proposed Timescale: a) completed, 29th September 2015, b) completed 30th September 2015, c) 31st October 2015, d) 31st October 2015 and ongoing, e) commenced and ongoing 29th September 2015, f) 16th October 2015, g) 31st October 2015 h) 9th September and ongoing) Completed 31st August 2015

Proposed Timescale: 31/10/2015

Theme: Safe Services

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

Staff working in the centre had not received updated safeguarding and safety training since the previous July 2015 inspection to ensure they had up to date comprehensive knowledge of client protection

27. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:

a) A Human Rights Based Approach to Adult Protection and Safeguarding Training Day was delivered to staff on 29th September 2015. Content was designed and delivered by an external facilitator and is available for review.

Proposed Timescale: 29/09/2015

Theme: Safe Services

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

Residents in the centre had not received training and knowledge of their rights and safeguarding issues. Training of this nature which would give them the skills and insight to identify incidents of abuse and bring them to the attention of the person in charge, for example.

28. Action Required:

Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Please state the actions you have taken or are planning to take:

a) An Adult protection, safeguarding and individual rights information session is being developed by the Learning & Development Manager in conjunction with Person in Charge. This will be delivered to all current residents, any new resident and will be repeated annually.

Proposed Timescale: 31/10/2015

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:

There was inadequate assessment of residents' education and employment needs for any resident in the centre.

Residents with greater dependency needs, for example, were not engaged in any meaningful process which would enhance their general welfare and development. This required review.

29. 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:

- a)The Service Provider has reviewed the Best Possible Health Assessment and is expanding it to include a section entitled "Interests & Activities" and another section entitled "Relationships & Personal Goals". This assessment will form the basis of the individual person Social Plan which will be monitored by the Social Supports Facilitator. Each resident will have an updated active Social Care Plan by 31st December 2015.
- b)Plans will be specific, time framed and actioned to ensure they are measurable and effective. Each plan will be discussed at a 6 weekly review.

Proposed Timescale: a) 30th November 2015 b) 30th November and ongoing

Proposed Timescale: 30/11/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

- Residents' nutritional risk was not monitored consistently.
- Some residents were assessed as being high risk of developing pressure ulcers. However, a care plan reviewed by an inspector was inadequate to mitigate the risk.
- Some residents had pressure ulcers which were managed using protective dressings to prevent further breakdown. However, there were no associated care plans in place outlining how wound healing was being assessed or to ascertain if there was an improvement or deterioration.
- Residents had not received an annual health check.

30. 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:

a)The nutritional requirements for residents at risk will be monitored by the Care Coordinator in consultation as required with Community Dietician Services. These will consider factors such as but not limited to; weight, dietary intake, dysphagia, specific dietary requirements, health and or cultural requirements where applicable, calorie intake where individual is utilising PEG Tube. Care Plans will be reviewed 8 weekly by both Care Coordinator and Regional Clinical Educational Facilitator (Nurse).

b)A nutrition risk assessment will be completed for all residents. Nutritional Management Plan will be developed for individuals as required based on Nutrition Risk Assessment outcomes. MUST assessments will be reviewed for all residents and

Dietician service engaged if required. These will be reviewed 4 monthly or as required due to change in circumstances by Care Coordinator.

c)A Preventative care plan to put in place for the prevention of skin breakdown and the development of pressure sores for residents at risk due to immobility. A Wound care plan will be put in place for any residents with a pressure sore , which includes a record of dates that pressure sore has been reviewed and whether there has been improvement or deterioration.

d)An information Session to raise awareness and knowledge of wound & pressure management will be delivered by the Care Coordinator at a Team Meeting 29th October. The Care Coordinator will further upskill by attending a training session delivered by INMO in Wound Management 13th November. Following this a further training session for staff will be developed and delivered by the Care Coordinator in conjunction with Cheshire Ireland Regional Trainer Nurse (19th November 2015).

e)A minimum 6 monthly service & inspection of specialist equipment, such as hoists and high/lo beds, will be scheduled. An annual pre planned maintenance schedule will be developed for wheelchairs, recliner chairs.

f)An ongoing review of specialist equipment will be incorporated into 6 weekly care plan reviews and amended as required.

g)Key healthcare issues for each individual will be identified and incorporated into their care plan, these will be monitored 6 weekly at care plan review by Care Coordinator Nurse. The Nurse will continue to liaise with the individual's GP around monitoring of the health of each resident and will refer for screening annually as per Best Possible Health Guidelines. This was last requested of individuals GP by Care Coordinator Nurse 09.09.15.

h)Staff will receive a documented training session at a Team Meeting in monitoring and management of pressure mattress equipment. A daily inspection of pressure mattress to be recorded as per care plan and monthly weights recorded to ensure mattress corresponds with weight.

Proposed Timescale: a), b) 30th November 2015, c) 31st October 2015 d) 29th October 2015 e) 31st October and ongoing f) 9th September commenced and ongoing g) 9th September commenced and ongoing 2015 h) 31st October 2015

Proposed Timescale: 30/11/2015

Theme: Health and Development

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

Associated care plans of which staff should follow in order to carry out health care recommendations were not in place.

31. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

Please state the actions you have taken or are planning to take:

a) Individual health care needs are identified in each person's care plan by the Care Coordinator Nurse, and specific care required is included, this will be reviewed to include recommendations by Allied Health Professionals.

b) A Record of each resident's recent health checks by medical professionals to be recorded and individual consultants listed.

c) Monthly blood pressure and weight checks will be carried out by the Care Coordinator Nurse and record of flu vaccine to be maintained as part of Best Possible Health documentation, this will be delivered by the individuals GP and recorded by the Care Coordinator Nurse.

Proposed Timescale: a), b), c) 10th September and Ongoing

Proposed Timescale: 10/09/2015

Theme: Health and Development

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

Residents' dental appointments were not documented in health care plans. Inspectors were not adequately assured that residents were supported to attend preventative dental health checks.

32. Action Required:

Under Regulation 06 (2) (e) you are required to: Support residents to access appropriate health information both within the residential service and as available within the wider community.

Please state the actions you have taken or are planning to take:

a) An annual dental check is offered to each resident as per Best Possible Health Guidelines and individuals are supported and encouraged to attend appointments. Dental care is included in each residents care plan and specific recommendations are included for residents with additional nutritional requirements. Dental checks will be reviewed and offered to all residents.

b) Care Plans and Dental requirements are reviewed 6 weekly by the Care Coordinator Nurse.

Proposed Timescale: 31/10/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not provide an adequate description of the size and layout of residents' 'studio apartments' as documented in the Statement of Purpose.

33. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

a)The Statement of Purpose and Residents Guide have been amended to ensure they thoroughly reflect the size and style of all apartments.

Proposed Timescale: 28/09/2015

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:

There were inadequate supervision and management systems in place which had direct negative impacts on residents. The person in charge was not adequately supported by the governance structures for the centre.

There was no system of reviewing the quality and safety of the service provided to residents in the designated centre.

34. 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:

The recently established Care Co-ordinator position has been increased to 30 hours per week, provided over 7 days. This position increases clinical supervision of care delivered, increases management presence in the Centre, provides direct on floor support to Care Staff and delivers on the job training & supervision in all clinical areas including medication management.

Recruitment has commenced for an additional position of a 20hrs Senior Care Support Worker role. This position will provide additional on floor supervision for the Care Staff

team and be a part of the local management team.

The Care Co-ordinator will act as PPIM in conjunction with the North Western Regional Manager and the Person in Charge.

Structured supervision meetings will be held with all Care Support staff on an 8 weekly basis with further supervision meetings as needed. Meetings will be documented and all staff will be met once by the Person in Charge before 31st October 2015 following delivery of a Safeguarding Session and Dignity at Work information Session.

The North Western Regional Manager will hold structured, documented support and supervision Meetings with the Person in Charge on a monthly basis.

The North Western Regional will provide fortnightly, verbal and monthly written reports to the Provider Nominee on progress and issues within the centre. The Provider Nominee will hold structured support and supervision meeting with the North Western Regional Manager on a monthly basis and minutes of this meeting will be documented. The Provider Nominee will receive regular updates from the Person in Charge through the Regional Manager but will also be available to contact or be contacted by the Person in Charge directly. The Provider Nominee will visit the centre twice a year. The Provider Nominee provides a report to each Board meeting on a six weekly basis progress with in the centre.

A review of the current quality audit system within Cheshire Ireland is underway. A working group has been appointed and the first meeting was held on 22nd July 2015. This group will ensure that a robust structure of audit will be in place within the organisation. A representative/s of the registered provider will carry out an unannounced visit by Cheshire Ireland Service Quality Team before 31st December 2015 and produce an annual review report on their findings.

A system of documented monthly unannounced visits will be carried out and documented by the Person in Charge and PPIM's .

Proposed Timescale: : a) completed (1st September 2015) b) 31st October 2015 c) 15th November 2015 and Ongoing d) 31st October 2015 and on-going e) Commenced (22nd September) & On-going f) Commencing 31st October 2015. g) 31st December 2015 h) completed 3rd October 2015 and ongoing.

Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

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

Management structures in the centre were clearly defined for staff working directly for the organisation but were not clear for staff that were not.

35. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:

a)Where residents are in receipt of shared services from another service provider this service is reviewed with the resident by the Person in Charge at monthly meetings. The Person in Charge will offer supports to the resident to manage and or direct their service as required or deal with any issues arising. Meetings will be documented and actioned as required including being raised immediately with the external Provider as necessary.

b)Quarterly meetings are held with the all External Service Providers. Shared services and their staff team's performance are reviewed at these meetings and issues or concerns are raised and addressed formally

Proposed Timescale: : a) 1st September 2015 and ongoing b)commenced 15.01.15 and ongoing

Proposed Timescale: 01/09/2015

Theme: Leadership, Governance and Management

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

The provider had yet to complete a report of the review of the safety and quality of the service as required by Regulations

36. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:

a)A review of the current quality audit system within Cheshire Ireland is underway. A working group has been appointed and the first meeting was held on 22nd July 2015. This group will ensure that a robust structure of audit will be in place within the organisation. A representative/s of the registered provider will carry out an unannounced visit by Cheshire Ireland Service Quality Team 31st December 2015 and produce an annual review report on quality and safety of the service areas for improvement and actions required.

Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

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

Improvement was required to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

37. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:

a) A Human Rights Based Approach to Adult Protection and Safeguarding training session for all staff has been held 29th September 2015.

b) A one day Dignity at Work learning and development information session for all staff has been delivered 30th September 2015. This was delivered by an external agency with expertise in the area of Human Resources. Learning from this will be incorporated into staff supervision and support sessions.

c) Structured Supervision and Support Sessions will be held 8 weekly by the Person in Charge with all staff. Formal sessions are scheduled for 27th & 28th October, 23rd & 24th November, 16th & 17th December.

Proposed Timescale:) completed 28th September 2015 b) Completed 29th September 2015 c) 27th October 2015.

Proposed Timescale: 27/10/2015

Theme: Leadership, Governance and Management

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

Inspectors were not satisfied that this arrangement robustly ensured adequate governance systems for the centre in the person in charge's absence.

38. 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:

a) The recently established Care Co-ordinator position has been increased to 30 hours per week, provided over 7 days. This position increases clinical supervision of care delivered, increases management presence in the Centre, provides direct on floor

support Care Support Staff, delivers on the job training & supervision in all clinical areas including medication management.

b)Recruitment has commended for an additional position of a 20hrs Senior Care Support Worker role. This position will provide additional on floor supervision for Care Support Staff. This post will be a part of the local management team.

c)The Care Co-ordinator will act as PPIM in conjunction with the North Western Regional Manager and the Person in Charge.The Regional Manager has commenced monthly supervision and support meetings with the Person in Charge. The Regional Manager is meeting each resident on a quarterly basis to seek resident's views their service and deal with any concerns raised.

Proposed Timescale: a) completed (1st September 2015) b) 31st October 2015 c) 16th October 2015

Proposed Timescale: 31/10/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

There was no weighing scales in the centre. A number of residents had significant mobility issues which would require specialist weighing scale equipment. This was not available and there was evidence to indicate residents were not weighed regularly to monitor for nutritional risk.

39. Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:

a)All individuals' weights have been reviewed & are accurate the Person in Charge is sourcing a permanent weighing scales for the designated centre. In the interim weighing scales have been provided by another service for use in the Centre. All weights are being monitored by the Care Co-ordinator.

Proposed Timescale: 31/10/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

While the provider had increased the nursing care provision for the centre, inspectors were not satisfied that they adequately provided for the nursing care needs of residents as evidenced in health care planning.

40. Action Required:

Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:

a)The Care Coordinator Post has further increased to a 30hour position to address additional support requirements, this role will involve protected time enable 6 weekly reviews of residents care plans and health care requirements.

Proposed Timescale: Completed and ongoing 1st September 2015

Proposed Timescale: 22/10/2015

Theme: Responsive Workforce

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

A sample of staffing records were reviewed as part of this Outcome. Of the sample reviewed none met the requirements of the regulations as set out in Schedule 2.

41. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:

a)A staffing audit against Schedule 2 Health Act 2007 (Care and Support of Residents in Designated Centres for People (Children and Adults) with Disabilities (Regulations 2013) will be completed Any gaps identified and outstanding documentation will be requested from individuals

Proposed Timescale: 30/11/2015

Theme: Responsive Workforce

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

Staff had not received up to date client protection training since the previous inspection.

Staff working in the centre were not able to operate electronic mattresses used to ensure they were kept at the correct setting for the resident.

Not all staff had received training in food hygiene despite being engaged in the preparation of resident meals on a regular basis.

42. 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:

- a) A Human Rights Approach to Adult Protection & Safeguarding Training sessions have been delivered to all staff.
- b) Instruction and demonstrations on the requirements and responsibilities around electronic mattresses will be carried out with all staff by the Care Coordinator.
- c) Food Hygiene Training will be sourced and delivered to staff that require it.

Proposed Timescale: a) Completed (28th September 2015), b) 31st October 2015, c) 30th November 2015

Proposed Timescale: 30/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Not all schedule 5 policies were in place at the time of inspection.

43. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

- a) Any outstanding Policies will be completed by the relevant support functions within the organisation and distributed to all services.

Proposed Timescale: 31/12/2015

Theme: Use of Information

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

While staff had access to policies for the organisation 'online', schedule 5 policies were not readily accessible in the centre in any other format.

There was no formal system to ensure staff had read and had an understanding of policies in place. Some hard copy policies available in the centre had been signed by some staff that they had read and understood them but in some instances only three staff signatures were documented.

44. Action Required:

Under Regulation 04 (2) you are required to: Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

Please state the actions you have taken or are planning to take:

- a) Schedule 5 Policies will be collated and maintained in a separate folder for ease of access and stored within the staff work station.
- b) The Person in Charge & Care Coordinator will commence a system of policy review with staff to ensure that all policies are read and understood .

Proposed Timescale: a) 31st October 2015, b) Commenced 1st October and ongoing

Proposed Timescale: 31/10/2015

Theme: Use of Information

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

A directory of residents was maintained but online and did not contain all the matters as set in the Regulations.

45. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:

- a) The current directory of residents is under review on an organisational level within Cheshire Ireland. A current hardcopy is printed and available. The data within is under review and will be updated to include all the requirements of Schedule 3 & 4 of the regulations (Health Act 2007 (Care and Support of Residents in Designated Centres for

People (Children and Adults) with Disabilities (Regulations 2013).

Proposed Timescale: 31/10/2015