Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0005342
Centre county:	Carlow
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Caroline Connelly
Support inspector(s):	Kieran Murphy
Type of inspection	Announced
Number of residents on the date of inspection:	0
Number of vacancies on the date of inspection:	0

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 1 day(s).

The inspection took place over the following dates and times

From:	To:
21 October 2015 08:45	21 October 2015 17:30

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 was a registration inspection of a Cheshire Ireland service which is one of a number of designated centres that come under the auspices of Cheshire Ireland. Cheshire Ireland provides a range of residential, and respite services throughout the country. Cheshire Ireland is governed by a board of directors. The responsibility for the operation of the organisation is delegated to a Chief Executive Officer (CEO) and a senior management team. The CEO is the nominated provider for the service. This centre provided care for residents with physical disabilities and neurological conditions.

This centre is a currently unoccupied building on the outskirts of a town that can accommodate four residents in a newly renovated two-storey house. The provider had applied to HIQA to register this house separately as a stand-alone centre. The registration inspection took place in conjunction with the registration inspection for the centre where the residents are currently living.

During the inspection the inspectors met residents, the provider, the person in charge, the assistant services manager, members of the management team, numerous staff members and relatives. Throughout the inspection inspectors observed practices and reviewed documentation which included residents' records, policies and procedures in relation to the centre, medication management, accidents and incidents, complaints, health and safety documentation and staff files. The person in charge works full-time and was seen to be very involved in the day-to-day running of the overall service. Staff and residents informed inspectors that the person in charge was accessible to residents, relatives and staff.

A number of questionnaires from residents and relatives were received and the inspectors spoke to the residents and a number of relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

There was evidence of individual resident’s needs being met and staff supported and encouraged residents to maintain their independence where possible. Community and family involvement was evident and encouraged as observed by inspectors. The inspectors observed evidence of good practice during the inspection and were satisfied that residents received a good standard of healthcare with appropriate access to their own general practitioner (GP), psychiatry and allied healthcare professional services as required.

However, the inspectors found that there were a number of non-compliances with the regulations and identified substantial improvements required in relation to fire safety, availability of nursing staff, skill mix, residents contracts of care, residents’ finances and protection, and health and safety also required improvement. The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013.

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors observed staff interaction with residents and noted staff promoted residents dignity while also being respectful when providing assistance. There was some evidence that residents were consulted about how the centre was planned and residents' meetings had taken place in the past.

However, the person in charge said that residents did not want meetings and preferred discussions on a one-to-one basis. The assistant manager and the person in charge told the inspectors they met regularly with residents to discuss issues but these discussions were not always recorded so there was not a contemporaneous record of discussions and actions taken in response to issues identified.

Inspectors were not satisfied that there was an effective complaints process in place to facilitate and support residents and or their relatives to make a complaint. There was a local complaints policy and the centre did maintain a complaints log. However, the complaints log did not always record if the complainant was satisfied with the outcome of the complaint.

The person in charge informed inspectors that she monitored safeguarding practices by regularly speaking to residents and their representatives, and by reviewing the systems in place to ensure safe and respectful care was provided. Inspectors observed staff endeavouring to provide residents with as much choice and control as possible by facilitating residents' individual preferences; for example, in relation to their daily routine, meals, assisting residents in personalising their apartments and their choice of activities.

Residents generally had their own self contained apartments which promoted their privacy and dignity. The inspectors saw personalised living arrangements in residents' rooms with photographs, personal effects and furniture. There was adequate space for clothes and personal possessions in all bedrooms and apartments with adequate wardrobes and lockers. The new centre will provide the same level of space and storage and personal effects will all be transferred over.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors noted that residents had access to appropriate media, such as television and radio. All residents had televisions in their rooms and many had their own computer or laptop and had access to the internet as required. There were plans that these will all transfer with the residents to the new house.

There was a communication policy available on the day of inspection and staff who spoke to inspectors demonstrated awareness of the individual communication needs of residents in their care and could outline the systems that were in place to meet the diverse communication needs of residents. In addition, inspectors noted that individual communication requirements including residents with complex communication needs had been highlighted in personal plans and were also reflected in practice. For example, inspectors noted that staff used communication approaches such as gestures, signals, facial expressions and vocalisations to communicate with some residents.

Inspectors noted from residents' personal plans that there had been input from multidisciplinary professionals, including speech and language therapists and occupational therapists to assist residents meet their range of communication needs. Staff to whom inspectors spoke outlined how residents were facilitated access, where required, to technology and communication aids.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspectors noted there was an open visiting policy and relatives could visit without any restrictions. Residents all had their own apartments or rooms which facilitated private visiting. Inspectors met a number of visitors in the centre during their inspection. There was evidence in residents' personal plans showing visitors attending the centre at different times as well as regular planned visits and this was confirmed by relatives who spoke to inspectors. This open visiting policy will be transferred to the new centre and there is space available for visitors. Relatives confirmed that they had visited and viewed the new centre and were happy with the arrangements and accommodation.

Inspectors saw and relatives confirmed that they were updated as required in relation to residents' progress and many relatives attended residents' review meetings. Inspectors saw in residents' personal plans that these meetings were held on a regular basis. There was evidence that residents' representatives could bring any issue directly to staff. Relatives and questionnaires confirmed to the inspectors that staff were very responsive to any such issues raised.

Inspectors saw that residents were supported to develop and maintain personal relationships and links with the wider community and families are encouraged to get involved in the lives of residents. Some residents went out to their family homes and relatives and this was all documented as part of their personal plans. Overall the inspectors saw evidence of good family involvement in care.

Judgment:
Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
The person in charge informed inspectors that all prospective residents and their representatives were afforded an opportunity to visit the centre on numerous occasions and speak to staff prior to admission. The offer of any place is made in consultation with the Health Service Executive (HSE) based on prioritisation. There was evidence that residents and relatives had visited the new house and liked their chosen rooms.

Inspectors found that the criteria for admission was clearly stipulated in the Statement of Purpose as per Cheshire Ireland's admission criteria that a person must be aged between 18 and 65 at the commencement of the service and have a physical disability or a neurological condition. Inspectors noted there was not a comprehensive admissions policy available and although the person in charge informed the inspectors that consideration was always given to ensure that the needs and safety of the resident being admitted were considered along with the safety of other residents currently living in the centre, this was not included in the admissions policy as required by the regulations.

Inspectors reviewed copies of the current written agreements in relation to the terms and conditions of residing in the centre. It was noted that the documents detailed the support, care and welfare of the resident as well as details of the services to be provided for that resident and the fee to live in the centre. However, the service agreement was not comprehensive and did not meet the requirements of legislation as it did not stipulate the fees to be charged in relation to extra services provided by the service such as transport, meals, private hours and all other items the resident had to pay for in addition to the rent.

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):
This was the centre's first inspection by the Authority.

Findings:
There was evidence that each resident was supported to develop an individual lifestyle plan every year. The lifestyle plan supported the resident to establish a circle of support made-up of family members, friends, neighbours and any others who the resident was close to and from whom they wished to receive support. The individual lifestyle plan detailed what was important to the resident and what they needed and wanted for a good life. The process was designed to have input from the resident, support workers and family to identify annual goals.

There was evidence of residents' involvement in setting residents' goals which were marked as priorities. However, improvements were required to the process of setting these priorities. A number of the goals set were not clear and measurable and did not have goal focused plans with meaningful outcomes for the residents. It was not always clear who was responsible for supporting the resident to achieve these priorities. Also, the supports required for residents to achieve their priorities were not always specified.

Inspectors saw that specific support plans were in place for residents' identified needs and to achieve the best possible health. This included plans for issues like intimate care, nutrition support and medication support. There was evidence of input from relevant healthcare professionals in the development of these support plans. There was evidence of multidisciplinary team involvement in residents' care including, medical and general practitioner (GP), speech and language, dentist and chiropody services. These will be discussed further in Outcome 11 healthcare needs.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The new centre is an eight bedroom two-storey house which includes the following communal accommodation: kitchen/ dining room, living room, utility room and bathroom.

Inspectors visited the house and saw that each resident will have a bedroom and bathroom of their own. Three of the bedrooms are downstairs and are en-suite with shower, toilet and wash-hand basin, and the fourth bedroom upstairs has a full en-suite also. There had been a very recent assessment by an occupational therapist of the needs of the resident for the upstairs bedroom. There was a stair lift in place to access the bedroom. The stair lift had a battery back up in the event of a power failure so that it could always be used. Staff were to accompany any resident who was using the stair lift. The occupational therapist recommended a sensor alarm for the upstairs bedroom and a customised stair gate to increase safety.

The house has been renovated to a high standard and included all the requirements of fire safety including fire doors, emergency lighting and fire alarm. The house was bright, well-ventilated, had central heating and was decorated to a good standard. There was adequate sitting and dining space separate to the residents' private accommodation which allowed for a separation of functions.
The other bedrooms upstairs are to be used for staff facilities and storage.

The house was set in the countryside with large mature grounds and car parking facilities. The garden was flat and there was an outdoor patio area to accommodate suitable garden seating and tables provided for residents use.
Laundry facilities were provided within the premise and were adequate. Staff said laundry is currently completed by staff but residents are encouraged to be involved in doing their own laundry.

Equipment for use by residents or people who worked in the centre where the residents were moving from included wheelchairs, specialised chairs, hoists, overhead hoists and other specialist equipment were generally in good working order and records seen by the inspectors showed that their servicing was up-to-date. A lot of this equipment will all be transferred over to the new centre once the centre is registered and ready to be used by residents.

Judgment:
Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
The risk management policy included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. However, specific

risk assessments in relation to hazards on the premises had not been completed fully.

There was no specific fire policy or overall guidance document in place for staff to respond to fire emergencies the designated centre.

As the building works to the premises were not yet completed there weren't records available in relation to:
• Servicing of fire alarm system and alarm panel
• fire extinguisher servicing and inspection
• servicing of emergency lighting.

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors saw that there was now an up-to-date policy on, and procedures in place for, the prevention, detection and response to abuse. Staff had been provided with training on adult protection and safeguarding. Prior to the inspection HIQA had been notified of an allegation relating to resident protection which was being followed-up with appropriately. However, inspectors were not satisfied that all potential resident protection issues were being escalated and managed appropriately. Both the complaints log and the incident reporting system contained resident protection issues which had not been formally reviewed to safeguard both staff and residents.

There was an up-to-date policy on the use of restraint which was in line with evidence based practice. The policy outlined that consent for the use of restraint had to be obtained from the resident, and also that there had to be multidisciplinary assessment of the appropriateness of restraint. Restraint in this context included lap belts, bed rails and belts on wheelchairs. The care plans reviewed by inspectors reflected the key points of the policy in relation to multidisciplinary assessment and consent. Care plans outlined risk assessments for the use of a lap belt, use of a bed rail and use of a bed table when in bed. Each risk assessment outlined the consideration of alternatives to the use of

restraint. Each restraint was subsequently risk rated and appropriate risk controls were seen. Inspectors also saw a register of all the types of restraint which were in use.

There was a policy on behaviours that challenge which outlined that alternative options were considered before a restrictive practice was to be used. However, there was no evidence in residents' personal plans that detailed behavioural support plans were in operation for residents who presented with behaviours that challenge and detailed de-escalation techniques were not outlined. There was evidence of review by the psychiatrist but there was little input from a psychologist and no behavioural plans prescribed. Training records showed and staff confirmed that staff had not received up-to-date training in the management of behaviours that challenge and due to the increasing number of incidents and staff working on their own at night this training should be provided to staff as a matter of priority.

The inspectors reviewed the system in place to manage residents' finances and overall the inspectors were not satisfied that the system was sufficiently robust to ensure the safeguarding of residents. Not all residents had access to their own bank accounts and their monies were still being managed centrally in the finance department in the centre.

The finance department paid bills for a number of residents and provided spending money for them via a 'shop account'. The shop account had been in practice for numerous years and is indicative of institutionalised practices. The person in charge informed the inspectors that they were trying to move all residents from this system to a more independent system where they managed their own finances with assistance from the key workers and all residents would have their own bank account.

Money competency assessments were being completed with residents and community connector staff were working with residents to encourage more independence. Inspectors saw evidence that residents were paying for extras such as transport, meals and private hours. These were not outlined in the residents contracts of care as discussed previously and inspectors were not satisfied that there were robust systems, policies and procedures in place to protect residents from misuse of the systems; particularly in the payment of regular staff for private hours and in the payments for transport.

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):
This was the centre's first inspection by the Authority.

Findings:
As this is a new centre currently not operational there were no notifications required but the provider and person in charge were aware of their future notification responsibilities.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspectors were satisfied that residents' opportunities for new experiences, social participation, education, training and employment were facilitated and supported. There was a policy on access to education, training and development. Inspectors noted that opportunities for further education were afforded to residents and the educational achievements of residents were valued. Many residents had their own laptops, computers and printers.

A community transition coordinator was working with residents and had completed a distinctive identity portrait which was a narrative journey through a person's life. This process also identified the person's wishes regarding where they wanted to live. Further stages in the process involved meeting with other stakeholders like family members, the HSE and community housing representatives. Comprehensive documentation regarding this transition was seen by inspectors to facilitate residents through the transition period and ensure they were prepared for community living in their new home.

Judgment:
Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
Residents' healthcare needs were met through timely access to GP services. Inspectors saw that residents were assisted to access community-based medical services such as their own GP and were supported to do so by staff who would accompany them to appointments and assist in collecting prescriptions as required. Out-of-hours services were provided by the local Caredoc service who attended to the resident at home if necessary. This service will continue in the new centre.

Residents had access to allied healthcare services which reflected residents' diverse needs. There was a physiotherapist employed one day per week and a physiotherapy assistant attended for two hours each day. Residents were seen to have appropriate access to other allied healthcare services such as occupational therapy, chiropody, optical and dental through the HSE and visits were organised as required by the staff. There was evidence in residents' records of referrals to and assessments by allied healthcare services and plans put in place to implement treatments required.

The centre was nurse-led and the inspectors saw there were a number of validated tools in place for measuring dependency, falls and nutrition and pressure sore formation. Inspectors found that there were a number of residents with complex physical and nursing needs who were assessed as having maximum dependency needs. Inspectors acknowledged that measures and equipment were put in place such as a specialist mattress, hoists and chairs however, the inspectors found (as outlined in outcome 17) that there was a requirement for extra nursing staff to prescribe and direct the care required for these residents, particularly in light of the nurse in charge being the only nurse in the service at the time of the inspection due to leave arrangements.

Residents' records were viewed and inspectors found that the records were contained in three different locations. The resident's active file, which detailed personal care planning, was contained in the resident's own apartment; the support file, which contained allied healthcare professional details, was kept in the treatment room; contracts for the provision of care and historical medical records were maintained in the main centre office. The person in charge outlined that this tri-location of records would be reviewed to avoid a communication failure regarding a health issue. This is actioned under outcome 18 residents' records.

In relation to nutrition, inspectors saw evidence that each resident had a malnutrition universal screening tool (MUST) completed. There was evidence that residents were supported and enabled to eat and drink when necessary and dietary plans were in place

as directed by the speech and language therapist regarding food consistency. In the new centre staff will provide meals in conjunction with the residents' likes, dislikes and dietary requirements.

Judgment:
Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors saw that the centre uses the Cheshire Ireland organisational policy on medication management but the policy was not centre specific and therefore did not outline local arrangements. This is actioned under outcome 18 in relation to records.

Inspectors saw that the pharmacist transcribed the prescription onto the medication administration sheet. This transcription was then signed as accurate by the GP. Inspectors saw evidence that the pharmacist was involved in the reviewing of residents' medications on-site on a regular basis and provided advice and support to staff. The person in charge said this service will transfer to the new centre. The input of the pharmacist had been sought in relation to medication management policies and procedures and there was evidence that the pharmacist was involved in the auditing of medication practices in the centre.

Medication was dispensed in blister packs for each resident. Inspectors saw that references and resources were readily accessible for staff to confirm prescribed medication with identifiable drug information. This included a physical description of the medication and a colour photograph of the medication which is essential in the event of the need to withhold a medication or in the case of a medication being dropped and requiring replacement.

There was a standard operating procedure on the administration of medication from a blister pack system. Inspectors saw the planned medication storage in the new centre and were satisfied that medication would be stored in accordance with best practice guidelines. There was secure storage available for controlled medications if required.

Each medication administration record had a picture of the resident on it. There was evidence that each resident was encouraged to take responsibility for their own medication in accordance with their wishes and preferences. There was a policy on self

administration of medication. There was a current standard operating procedure on the reporting and recording of medication errors. Inspectors saw, and training records confirmed, that medication refresher training had been provided to all staff and there was evidence of the nursing staff completing assessments of care staff's practices in relation to medication administration.

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):
This was the centre's first inspection by the Authority.

Findings:
A recently updated Statement of Purpose was available for the new centre and it reflected the day-to-day operation of the centre and the services and facilities provided in the centre. The person in charge confirmed that she kept the Statement of Purpose under review and provided the inspectors with a copy of the most up-to-date version.

The Statement of Purpose was found to be comprehensive and contained all the relevant information to meet the requirements of legislation.

Judgment:
Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Cheshire Ireland provides a range of residential and respite services throughout the country. Cheshire Ireland is governed by a board of directors. The responsibility for the operation of the organization is delegated to a Chief Executive Officer (CEO) and a senior management team. The CEO is the nominated provider for the service and the service manager for the centre is the person in charge. There is an Eastern regional manager who the person in charge reports to. The person in charge is supported in her role in the centre by the assistant manager and a clinical nurse manager level 1 (CNM1) care team leader.

There was also a quality services manager, a head of support services, head of maintenance, lifestyle coordinator, an administrator, senior care workers and community transition coordinators as part of the management team.

The service manager is the person in charge for the service. The person in charge works full-time and has only managed the service for a number of months but was working in the service as a nurse prior to taking on the person in charge role. There was evidence that the person in charge had a commitment to her own continued professional development. The person in charge is a qualified general nurse and children's nurse. Inspectors formed the opinion that she had the required experience and clinical knowledge to ensure the effective care and welfare of residents in the centre.

Inspectors noted that residents and relatives were familiar with the person in charge and said they could speak to her if necessary. Residents and staff identified the person in charge as the one with overall authority and responsibility for the service. Staff who spoke to the inspectors were clear about whom to report to within the organizational line and of the management structures in the centre. The assistant service manager takes responsibility for the centre in the absence of the person in charge. Additionally, the person in charge is available on call and staff told inspectors that they have called her in the past.

Inspectors noted that the person in charge and staff generally demonstrated a positive approach towards meeting regulatory requirements. Although this is a new centre there was no evidence of the provider or a nominee on behalf of the provider undertaking unannounced visits of the centre and there were no reports available in relation to its suitability. There was limited evidence of audits undertaken and inspectors were not satisfied that the system implemented to monitor the quality of care and experience of the residents was adequate to ensure the delivery of safe, effective services.

Judgment:
Non Compliant - Moderate

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:
This is a new centre so there has been no absence of the person in charge. Inspectors were satisfied with the proposed acting up arrangements put in place to cover for the absence of the current person in charge. The assistant service manager will act up as person in charge for the period of absence and she will be supported in her role by the clinical nurse manager and management team.

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):
This was the centre's first inspection by the Authority.

Findings:
The person in charge told the inspectors that residents' care would not be compromised by lack of budget and if specialist equipment was required funding would be provided. Inspectors saw that there was sufficient assistive equipment to meet the needs of residents with servicing records for assistive equipment up-to-date. The inspectors noted that there was accessible transport services provided for residents which the service charges for.

Inspectors formed the opinion that the centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose. The new premises were inspected and the house had been renovated to a high standard to ensure compliance with regulatory requirements.

There were suitable healthcare staff and nursing staff on call and available to assist residents 24 hours a day for each day of the year.

Judgment:
Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
The person in charge informed the inspectors that there will be staff present in the new centre 24 hours per day; with three staff on in the morning and during the day. Staffing levels will reduce to one staff member at night and the person in charge said assistance can be sought at night from staff working in the other services. However, these services a five to 10 minute drive away and this could result in delays in care. The inspectors required that staffing levels be kept under full review to ensure the needs of residents at night are fully met and staff safety travelling between areas has been risk assessed.

The residents will be supported to access external facilities in the community and will be allocated five hours per week social support to enable them to do so. They will also have access to community employment workers and volunteers. The service employed a lifestyle facilitator who coordinated all the personal assistants for residents, community employment workers and volunteers. A number of volunteers had been placed in the centre via the European Voluntary Service (EVS) programme. Each of these volunteers had to submit an expression of interest and an independent assessor inspected the service to see if it was suitable for placement. A Garda Síochána vetting was undertaken by the EVS programme. Inspectors saw that there was a handbook for all volunteers. A completed Garda vetting form, a signed application form, three references and photographic identification were on file.

Inspectors spoke to staff and observed them at work with the residents. Staff were knowledgeable about each resident's needs and interacted with them in a respectful and dignified manner. Inspectors also spoke to some family members who were very complimentary about the staff that worked in the centre. Most staff had completed training which was required as mandatory by the regulations; with the exception of training in behaviours that challenge and this is actioned under Outcome 8. Further

education and training was also available to staff to ensure their knowledge base was current.

Inspectors reviewed a sample of staff files and although they contained evidence of Garda Síochána vetting, photographic identification and detailed work histories, inspectors found that written references remained outstanding for two staff members and there was no evidence of relevant qualifications in another file; therefore they did not met the regulatory requirements.

Nursing staff were employed between 08:00 to 17:00 between Monday and Friday. There was no nursing staff on duty at night and nurses were not on duty at the weekend. However, there were arrangements in place for a nurse to attend for three hours at some stage during the weekend. There was an on-call system at the weekend for nurses and management should staff have any queries. During the inspection, and for a number of weeks due to unplanned leave, the person in charge was the only nurse covering the service. This level of nursing cover is not satisfactory as the person in charge's nursing duties were never replaced when she took the person in charge role. Due to the complex and maximum dependencies of many of the residents these nursing arrangements require immediate review and this was outlined at the feedback meeting.

There was evidence of staff meetings held but there were no minutes or records of recent issues discussed at the staff meetings and little evidence of any discussion in relation to the move to the new centre.

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):
This was the centre's first inspection by the Authority.

Findings:
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

were generally maintained. The centre was adequately insured against accidents or injury to residents, staff and visitors.

Staff to whom inspectors spoke with demonstrated an understanding of specific polices such as medication policy and managing allegations of adult abuse in practice. However, the inspectors reviewed the centre's policies and procedures and found that the centre did not have 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. The admissions policy and policies in relation to records management were not available. The medication policy as discussed under outcome 12 was not centre specific.

In relation to residents' records, as discussed in outcome 11, inspectors saw that there were numerous files maintained for each resident and that the records were contained in three different locations. The resident's active file, which detailed personal care planning, was contained in the resident's apartment; the support file, which contained allied health professional details, was kept in the treatment room; contracts for the provision of care and historical medical records were maintained in the main centre office. Therefore information in relation to residents was kept in various locations and there was duplication of information at times which could lead to the most current information not being available to guide care and treatment.

Inspectors reviewed the directory of residents and noted that the directory was completed for each resident and contained the required information.

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:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0005342
Date of Inspection:	21 October 2015
Date of response:	1 December 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:
The assistant manager and the person in charge told the inspectors they met regularly with residents to discuss issues but these discussions were not always recorded so therefore there was not a contemporaneous record of discussions and actions taken in response to issues identified.

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

1. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
A meeting record form has been implemented by the Person in Charge and Assistant manager which is now used to document meetings held with service users , actions taken and responses to issues identified. This is kept on file in main office.

Proposed Timescale: 01/12/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints log did not always record if the complainant was satisfied with the outcome of the complaint.

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

Please state the actions you have taken or are planning to take:
• The complaints form is currently under review and new version will include section to document whether the complainant was satisfied or not.
• The service has an electronic complaints database that is completed when complaints are made which includes a section to document whether complainant is satisfied with outcome.
• Currently the Service has implemented an associated document with complaints form which allows the nominated person to document whether complainant is satisfied or not.

Proposed Timescale: 29/02/2016

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:
There was not a comprehensive admissions policy available and the policy did not take account of the need to protect residents from abuse by their peers.

3. Action Required:
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
A revised Admission Policy has been introduced by Service Quality Team for Cheshire Ireland in November 2015 which includes taking into account the need to protect residents from abuse by their peers

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The service agreement was not comprehensive and did not meet the requirements of legislation as it did not stipulate the fees to be charged in relation to extra services provided by the service such as transport, meals, private hours and all other items the resident had to pay for in addition to the rent.

4. 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:
• Currently the Service Agreement is under review by Person in Charge with support from the Service Quality Team to ensure the agreement complies with regulation.
• The person in charge will implement an addendum to the current Service Agreement which will outline fees to be charged in relation to extra services provided by the Service to the Service User such as transport , meals , private hours.

Proposed Timescale: 31/01/2016

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:
Those responsible for supporting residents in pursuing goals were not always clearly identified nor were the supports outlined.

5. 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 full review of all Service User's lifestyle plans will take place by Nursing and Care Staff Team to include each Service User's key care support worker.
• New amended lifestyle plans will be implemented with clear goals identified and a plan formulated to outline how these individual goals will be achieved.
• An audit will take place each quarter in 2016 to ensure Service User's goals being pursued have been successful and meaningful.

Proposed Timescale: 01/03/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Specific risk assessments in relation to hazards on the premises had not been completed fully.

6. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
• A gap analysis is currently being undertaken by the Health and Safety Officer on The Risk Management and Safety Management system of Cheshire. On review of this the risk management system will be adapted.

• Safety Representative training program is being drafted and the safety representative training will take place at St. Patricks. This will give the safety rep the tools required to assist him to carry out this function while ensuring the risk culture is communicated and corrective actions are put in place to remove the risks.

• Health and Safety Officer will conduct training for staff around how to conduct risk assessment. Ongoing to drive the safety culture and the importance of risk elimination.

• Health and safety meetings to be held monthly until April 2015.Continiung the importance of risk communication .Reduce risk and eliminate risk when possible.

• The Health and Safety Officer, SM, Staff, and the safety representative to conduct the following risk assessments which in turn will aid the service in managing risk throughout the service.

• Types of Risk Assessments:
1. Site specific risk assessments
Generic risk assessments

• Risk management training to be undertaken with key staff in the service.

• Health and safety training to be given to staff in the service to assist with ongoing improvements in safety culture and communication throughout the service.

• A Self-Assessment Health & Safety Audit has been drafted by the new Health and Safety Officer. The Service Manger will complete this audit bi -monthly and send to HSO for review. This audit tool will assist the service to ensure health and safety auditing is ongoing. Both The Health and Safety Officer and The SM will review the risks together in the service. The following areas will be audited, safety, fire safety, security, food safety and compliance documentation.

• Unannounced and announced risk management audits will be undertaken on an ongoing basis by The Health and Safety Officer. Findings and results of these internal audits will allow Cheshire to determine if the new safety practices, life safety systems and emergency plans are operating and facilitating the service correctly.

• Health and safety meetings to be held monthly until April 2016.Findings on adverse events, and other health and safety issues/corrective etc. etc. to be discussed with staff and residents.

Proposed Timescale: 30/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There wasn't a specific fire policy or overall guidance document in place for staff to respond to fire emergencies in the designated centre.

7. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
Fire policy is currently under review to be site specific to Wolseley Lodge to include guidance document /evacuation plan for the designated centre.

Proposed Timescale: 31/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As the building works to the premises were not yet completed there weren't records available in relation to:
• Servicing of fire alarm system and alarm panel
• fire extinguisher servicing and inspection
• servicing of emergency lighting.

8. Action Required:
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
Plans in place to implement service plan, once designated centre has been registered by HIQA and service users move into their new home, for servicing of fire alarm and alarm panel, fire extinguisher servicing and inspection and servicing of emergency lighting.

Proposed Timescale: 31/01/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was limited multidisciplinary input and prescribed behavioural plans input to ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

9. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
• Person in charge has in conjunction with the assistance of National training and development manager for Cheshire Ireland sourced training with accredited training company Joe Wolfe and Associates to facilitate training with staff on positive behavioural support.
• A qualified psychologist named Margaret Costello based in Carlow has been sourced to facilitate training in challenging behaviour with specific care staff looking after one service user who has been identified by service as challenging. She will provide training for staff on how to deal with this and also assist in implementing behavioural support plan around this gentleman.
• New Policy on Positive Behavioural Support has been introduced by Cheshire Ireland

and has been introduced into the service for staff.

Proposed Timescale: Policy Implemented November 2015 and all staff will be trained by 28th February 2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received up to date training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Please state the actions you have taken or are planning to take:
Psychologist and Accredited Training Company have been sourced to facilitate training in challenging behaviour including de-escalation and intervention techniques.

Proposed Timescale: 28/02/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place to manage residents finances were not sufficiently robust.

The inspectors saw evidence that residents were paying for extras such as transport, meals and private hours. These were not outlined in the residents contracts of care and the inspectors were not satisfied that there were robust systems, policies and procedures in place to protect residents from misuse of the systems particularly in the payment of regular staff for private hours and payments for transport.

11. 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:
• Service Agreements for Service Users to be amended to include an outline of extra payments around transport, meals and private hours.
• Working Group with Service Quality Team lead has been formed to review Service Users contracts of care around private hours and transport.
• The function of this group is to recommend policy and procedures around the use of private hours and transport to ensure a more robust system governing this in the Services and to ensure policy and protocols that are implemented protect residents.
• Person in Charge is a member of this working group and will be involved in

implementing these changes in the service.

Proposed Timescale: 31/03/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors were not satisfied that the system implemented to monitor the quality of care and experience of the residents was adequate to ensure the delivery of safe, effective services.

12. 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 service user questionnaire/survey is currently being drafted by Service Quality Team which will be circulated in the New Year and feedback from survey will be reviewed to ensure the service we provide is safe, appropriate to residents needs.

Proposed Timescale: 31/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors were not satisfied that there were sufficient nursing staff to meet the ongoing nursing needs of the residents and to provide supervision to the care staff.

13. 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:
Currently the service has 1 WTE CNM 1.

Consultation is taking place with senior management around new community structure and requirement for nursing supervision as the service evolves. When nursing hours are agreed recruitment and selection will commence. Recruitment has commenced to cover maternity leave for current CNM1 from January 2016.

Proposed Timescale: 31/01/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All the information and documents as specified in Schedule 2 were not obtained for all staff.

14. 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:
• All staff files are currently being reviewed to ensure all documents required are obtained for all staff.
• Files that were reviewed during inspection now contain all documents required under regulations
• It is proposed to perform bi-annual audit of files using requlations to ensure staff files in the Service contain all documents required.

All files will have been reviewed by 31st March 2016.
File Audit to take place 10th May 2016 and 10th November 2016.

Proposed Timescale: 31/03/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not have 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. In that the admissions policy and policies in relation to records management were not available and the medication policy was not centre specific.

15. 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:
• Admission Policy (revised) has been implemented and on Cheshire Ireland website.
• Records Management Policy currently being drafted.
• Medication Policy is currently under review and once implemented will be amended to

be centre specific.

Proposed Timescale: 29/02/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents records and information in relation to the residents were kept in various locations and there was at times duplication of information which could lead to the most current information not being available to guide care and treatment.

16. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
• A full review of files will be undertaken by CNM1 and Service Manager.
• Consultation will take place with Clinical Lead of Cheshire Ireland.
• New filing system will be implemented to ensure service users information being reviewed and used on a daily basis is the most current and up to date information to guide care and treatment.

Proposed Timescale: 30/04/2016