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 Cheshire Foundation in Ireland (t/a Cheshire Ireland)
Centre ID:	ORG-0011354
Centre county:	Waterford
Email address:	mark.blakeknox@cheshire.ie
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Cheshire Foundation in Ireland (t/a Cheshire Ireland)
Provider Nominee:	Mark Blake-Knox
Person in charge:	Cabrini de Barra
Lead inspector:	Kieran Murphy
Support inspector(s):	Ide Batan;
Type of inspection	Announced
Number of residents on the date of inspection:	13
Number of vacancies on the date of inspection:	5

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 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 monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
04 March 2014 10:00	04 March 2014 17:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was a monitoring inspection of a service which provided accommodation and support to people with physical disabilities and neurological conditions.

The facility provided accommodation to 13 residents, with three vacancies for the provision of respite care. There was the capacity to accommodate 18 residents in total. Each resident had an accessible self contained apartment. A number of apartments were located on the first floor and were accessible by lift. The lift doors opened automatically on approach, thus no use of hands was required. Some other apartments were used as offices for other community services.

Inspectors met with residents, the person in charge, the clinical care team coordinator and other staff members. The person in charge was involved in day to day management and was found to be easily accessible to residents, relatives and staff. Community and family involvement was encouraged as observed by inspectors. A number of residents specifically stated that the care in the centre was of a very high standard.

Inspectors found that the service did not meet all of the requirements of the Health Act 2007 Care and Support of Residents in Designated Centres for Persons(Children and Adults) with Disabilities) Regulations 2013 in relation to:

•care planning

•discharge planning
•review by health care professionals
•fire safety
•training to protect people from abuse and neglect
•medication safety
•statement of purpose.

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
There were three documents outlining admissions to and the contract for the provision of services. The first was the statement of purpose and this will be discussed more fully in outcome 13 of this report. The other documents were a service agreement and a tenancy agreement.

Inspectors viewed a sample of service agreements which were signed by the resident and the service provider. Each admission had been determined on the basis of transparent criteria in accordance with the statement of purpose. Each resident and their family were provided with an opportunity to visit before admission. The service agreement was in writing and outlined the terms on which each resident resided there. The agreement also outlined the support care and welfare of the resident and the details of the services to be provided for that resident.

Inspectors reviewed a sample of a tenancy agreement which were signed by the resident and the service provider. This agreement set out obligations in relation to issues like rent, landlord duties, premises, insurance, succession, guests, repairs and rubbish collection. It also covered issues like notice of termination of contract and termination of tenancy for breach of contract.

Neither the service agreement nor the tenancy agreement outlined the provisions whereby a resident may be requested to vacate the service due to ill health. Residents spoken with by inspectors had expressed their anxiety about the potential for discharge from the service due to deterioration in health. The person in charge and staff spoken with stated that a resident had never been discharged from the service. However, inspectors formed the opinion that clarity needed to be provided on the area of discharge from the service. This will be discussed also in Outcomes 5 (transition and discharge planning) and 13 (statement of purpose).

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

Judgement:
Non Compliant - Major

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors reviewed a sample of medical records and personal care plans. The records viewed had two aspects, the care plan and the recording of allied health support. Inspectors concluded that there was no evidence of ongoing comprehensive care planning. One resident had a clearly documented care plan drawn up in February 2014 by the resident and their general practitioner (GP). However the care plan for the resident was only initiated following a post operative wound infection. Another resident had not been seen by a specialist consultant to manage their illness in over five years.

The care planning records reviewed also covered issues like high blood pressure, diabetes, diet, pressure sores and manual handling. Personal care planning was documented for the activities of daily living like dressing, personal hygiene and elimination. For one resident these were not current and had last been reviewed in February 2013.

In relation to temporary absence from the service there were planned supports in place where a resident had to be admitted to hospital. There was evidence that the key care worker completed a medical transfer form with sufficient detail for the hospital to get a clear history of the resident's needs. If required the care worker would stay with the resident for the duration of hospitalisation.

In relation to discharge from the service, following review of care plans, review of service agreements, review of tenancy agreements and from conversations with residents inspectors were not satisfied that arrangements for discharge were transparent. There was no evidence that a discharge would take place in a planned and safe manner. Neither was there any evidence of arrangements as to how a discharge would be discussed, planned for and agreed with the resident.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The fire register was comprehensive and included accurate architectural drawings, up to date emergency lighting records, up to date maintenance records of fire extinguishers, current service records for fire hose reels and a completed check list of daily and weekly fire checks. Fire evacuation maps were displayed prominently and there had been seven fire evacuation drills since June 2013. Each resident had their own personal evacuation plan. Staff and residents spoken with were aware of the arrangements for evacuation in the event of fire.

There was a policy for the management of fire safety dated 2012. However this policy was incomplete as it referred to instructions in appendices to the policy which were not available. The fire alarm system had been tested and inspected in November 2013 with a recommendation that a fire detector be placed in the electrical room and an updated fire panel was required.

There were two types of fire training, fire warden and basic fire training. Nine staff had not completed one or other of this fire training since November 2012.

Inspectors reviewed a comprehensive major emergency plan dated October 2013. This outlined arrangements for issues including storm damage, power failure, gas leak and loss of water. It contained arrangements for medical and pharmaceutical support in the event of an emergency. It outlined a personal health plan for each resident and an alternative short term destination for each resident in the event that the centre had to be evacuated. Of note is that a second emergency plan was seen by inspectors but this had last been reviewed in 2006.

There was no risk management policy. There was an incident reporting system in place and inspectors reviewed a sample of incidents for the last six months. Each incident was reported and followed up appropriately. The format of the incident report form had changed in January 2014 and the updated form did not have a review section to prevent the recurrence of an incident or accident.

Risk assessment training had last been completed in 2005. However staff workshops on clinical risk assessment and supporting risk management plans were scheduled for April 2014.

There were two vehicles available to transport residents. Inspectors reviewed records of the vehicle log book detailing the journeys undertaken. There were records of insurance and motor tax on file. However up to date national servicing of vehicle records or driver assessments were not on file.

There was good practice seen in relation to control and prevention of infection. Hand gels were available throughout the premises and staff did take opportunities to wash their hands and use hand gels. There was a policy for the management of waste which had been last reviewed in February 2011. The safety statement outlined arrangements for clinical risk including the disposal of clinical waste. Clinical waste was disposed of in separate designated bins.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
An up to date adult protection policy was in place for the prevention, detection and response to abuse. There were comprehensive systems in place to respond to any allegation of abuse. One investigation, seen by inspectors, had been undertaken by the service manager and reviewed by the regional manager and the service quality manager of the organisation. This investigation had followed up an incident appropriately and the outcome had been communicated in an open and transparent manner.

Staff with whom inspectors spoke knew what constituted abuse. However, not all staff were trained in abuse as required by the legislation.

There was a current policy on the use of restraint which was in line with national policy and evidence based practice. There was a restraint register in place which identified the types of restraint used including lap belts, bed rails and belts on wheelchairs. There was an action plan in place for the supported implementation of the restraint policy.

There was evidence available that staff had received two days training in behavioural support which dealt with assessing risk in line with best practice for any resident that

required the use of restraint. The personal care plans adequately detailed the use of restraint, consent in relation to the use of restraint or the supervision and observation of a resident while restraint was in use. There was evidence that reviews of care plans were being undertaken in relation to use of restraints.

There was a policy in place on supporting people to manage their own money and a money management support plan was available.

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Judgement:
Non Compliant - Major

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Residents were actively encouraged to take responsibility for their own health and medical needs. Each resident maintained control of their medical information in their own apartment. Each resident had their own GP and staff accompanied residents to doctor's appointments.

The person in charge outlined that referral to allied health professionals was organised also by the residents themselves. There were no priority arrangements in place for residents to access health professionals and the service provider did not facilitate access to allied health professionals. The residents' health support file contained nursing notes, doctors' notes, and reference to other health professionals like speech therapy, dietetics and physiotherapy but there was no evidence of an annual multidisciplinary review of residents' care needs which is a requirement of regulation.

The care team coordinator supervised clinical care and delegated care to non nursing staff. The care team coordinator also provided training to staff on different aspects of clinical care that may arise like catheter care, percutaneous endoscopic gastrostomy (PEG) feeding and stoma care. There were some examples of staff supporting residents to achieve the best possible health and in one instance a resident with complex care needs had been supported with intensive physiotherapy and significant improvements had been noted.

In relation to food and nutrition residents were supported by staff to prepare meals in their own kitchen in their apartments. Residents discussed meal plans with staff. There was evidence of monitoring and documentation of nutritional intake with residents' care plans outlining arrangements in relation to diet. In communal areas there was access to

snacks and drinks if required.

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Practices in relation to medication management required improvement. There was a written operational policy relating to medication management which addressed medication management by nursing and care staff. Each prescribed medication was signed by a GP who also reviewed residents' prescriptions every six months.

Medication was dispensed by a pharmacist in tamper proof packs every four weeks. The dispensed medication was colour coded in relation to administration times. The medication administration record sheet had a picture of each medication with a description of the medication included. When medication was dispensed by pharmacy the prescription was checked against the medication administration record. However, there was no evidence of appropriate support for residents in dealing with the pharmacist. The pharmacist did not visit the residents or provide a review of prescribed medications. In relation to unused medication there was no records kept of which medications were returned to pharmacy.

Some residents were responsible for their own medication following an appropriate assessment and residents signed a form to this effect. However, there was no system in place for staff to check if residents who were self medicating were taking their tablets. Inspectors observed the practice of one resident who was storing her dispensed medication in egg cups on the dining table. The resident then self administered the medication without any monitoring system in place from staff.

The medication management policy outlined that all staff were to attend training on medication management. Some staff had not attended this training. There was evidence of a system of audit of medication administration practice, the last of which was completed in 2013.

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

Judgement:
Non Compliant - Minor

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
There was a written statement of purpose that described the service provided.

The services and facilities outlined in the statement of purpose for the most part did reflect the manner in which care was provided and reflected the diverse needs of residents. The only restriction to care provision outlined in the statement of purpose was that individuals seeking to access the services had to be between the ages of 18 and 65 when they first arrived. There was no reference in the statement of purpose to alternative accommodation being sought in the event of a change in a resident's dependency level.

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

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The person in charge was employed full time and was a professionally qualified social worker. She had extensive social care experience. She was an accredited trainer in measuring personal outcome for people with disabilities. The person in charge

demonstrated sufficient knowledge of the legislation and her statutory duties. Residents spoken with were satisfied that the person in charge managed and administered the centre in a consistent manner.

At an operational level the management team consisted of the person in charge with the support of the care team coordinator who was a registered nurse. The care team coordinator deputised for the person in charge when absent. The person in charge reported to a regional manager.

There were management systems in place to review whether the service was safe and appropriate to residents' needs. A service quality team had been established in November 2013 to provide a forum for meaningful consultation with residents and family members. Inspectors reviewed minutes of the meeting from February 2014 and the feedback from residents' including more activities, concerns about reduced staffing at the weekends and the possibility of cinema listings being displayed on the notice board. All of these issues had been reviewed and addressed by the person in charge. There were also staff meetings and care team meetings which were held monthly. These meetings were forums for staff to raise concerns about quality or safety. The minutes of the staff meeting outlined issues like support for a service user whose needs had changed, fire drills dates and the implementation of a money management policy.

There was evidence that review of the quality of care was being undertaken. In 2012 an audit of services had been undertaken by the service quality manager. This audit looked at issues like staffing, protection, health, rights and governance. In total 68 actions were identified, which the person in charge had used as a basis for service quality improvement.

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

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors reviewed a sample of staff files and all files met the regulatory requirements in relation to Garda Síochána vetting, documentary evidence of any relevant qualifications, photographic identification and two written references.

The inspectors were satisfied that the numbers of staff available during the inspection was appropriate to meet the assessed needs of residents at all times.

Some residents had their own dedicated staff teams providing one-to-one care. This arrangement ensured continuity of care. Some residents managed their own staffing allocation and residents were involved in the recruitment and selection of these staff.

Based on observations of inspectors staff members were knowledgeable of residents individual needs and provided assistance to them in a respectful, caring and timely manner.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Kieran Murphy
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 report[1]

Centre name:	A designated centre for people with disabilities operated by Cheshire Foundation in Ireland (t/a Cheshire Ireland)
Centre ID:	ORG-0011354
Date of Inspection:	04 March 2014
Date of response:	28 March 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:
The service agreement did not outline the provisions whereby a resident may be requested to vacate the service due to ill health.

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:
Admissions & Discharge Policy and Procedure to be developed and included in all

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

Service Agreements. Person Responsible: Service Quality Team.

Proposed Timescale: 31/07/2014

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:
A care plan for a resident was only initiated following a post operative wound infection.

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:
The Care Team Coordinator will ensure that all care plans are routinely reviewed every three months.

The Care Team Coordinator will review and update all care plans when a person's needs change, including post surgery and any change or deterioration in health. Effective from 29th April 2014 onwards

Proposed Timescale: 29/04/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident had not been seen by a specialist consultant to manage their illness in over five years.

Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
The Care Team Coordinator will discuss options with the individual resident and contact the consultant to request an urgent appointment to review the individuals health status and needs. Date for consultation to be arranged by 12th May 2014.

Proposed Timescale: 12/05/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no arrangements in place for how a discharge would be discussed, planned for and agreed with the resident.

Action Required:
Under Regulation 25 (4) (e) you are required to: Ensure the discharge of residents from the designated centre is in accordance with the terms and conditions of their agreements for the provision of services.

Please state the actions you have taken or are planning to take:
Admissions & Discharge Policy and Procedure to be developed. Person Responsible: Service Quality Team

Proposed Timescale: 31/07/2014

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:
There was no risk management policy.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Cheshire Ireland's current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (i). Person responsible: Risk Manager

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy that included the measures and actions in place to control the risks identified.

Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
Cheshire Ireland's current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (b). Person responsible: Risk Manager

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy that included arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
Cheshire Ireland's current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (b). Person responsible: Risk Manager

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no a risk management policy that included arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Action Required:
Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Please state the actions you have taken or are planning to take:
Cheshire Ireland's current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (b). Person responsible: Risk Manager

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy that included the measures and actions in place to control the unexplained absence of a resident.

Action Required:
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

Please state the actions you have taken or are planning to take:
Cheshire Ireland's current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (i). Person Responsible: Risk Manager

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy that included the measures and actions in place to control accidental injury to residents, visitors or staff.

Action Required:
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
Cheshire Irelands current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (ii). Person Responsible: Risk Manager

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy that included the measures and actions in place to control aggression and violence.

Action Required:
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
Cheshire Ireland's current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (iii). Person Responsible: Risk Manager.

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy that included the measures and actions in place to control self-harm.

Action Required:
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
Cheshire Irelands current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (iv). Person Responsible: Risk Manager

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy or systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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:
Cheshire Irelands current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (2). Person Responsible: Cheshire Ireland

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Up to date National Car Test (NCT) certificates, servicing of vehicle records or driver assessments were not on file.

Action Required:
Under Regulation 26 (3) you are required to: Ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

Please state the actions you have taken or are planning to take:
All required documentation for the vehicle is on file and up to date.

Proposed Timescale: 05/03/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire safety policy was incomplete as it did not contain centre specific information. The policy also referred to appendices which were not included with the policy.

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:
A) A Review of Fire Policy and associated documentation to take place to ensure it is centre specific
B) The file to be updated to include relevant appendices

Review to commence 23rd April 2014. Work to be completed to the requirements by 31st May 2014. Person Responsible: a) Risk Management/Health & Safety Coordinator, b) Service Manager

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff had not completed fire training.

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:
Fire Warden Training planned for 13th May 2014. 15 staff identified as currently untrained are scheduled to attend. Person Responsible: Service Manager

Proposed Timescale: 13/05/2014

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:
All staff had not received training on the prevention and detection of abuse.

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:
Adult Protection Training planned for 4th June 2014. 10 staff identified as currently untrained scheduled to attend. Person Responsible: Service Manager

Proposed Timescale: 04/06/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no priority arrangements in place for residents to access health professionals. There was no evidence of an annual multidisciplinary review of residents' care needs.

Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
The Care Team Coordinator will ensure that all residents have referrals made to required allied health professionals in a timely manner. Where there is a delay in

accessing a service the Care Team Coordinator will communicate this to the Service Manager and other alternative arrangements will be considered to ensure access to the relevant professionals in a timely manner.

All health professionals involved in and relevant to the provision of services and supports to individuals will be invited to annual review meetings going forward.

From 22nd April to 30th September 2014 at least one multidisciplinary review meeting will take place for each person.

Person Responsible: Service Manager and Care Team Coordinator

Proposed Timescale: 30/09/2014

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of appropriate support for residents in dealing with the pharmacist. The pharmacist did not visit the residents or provide a review of prescribed medications.

Action Required:
Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

Please state the actions you have taken or are planning to take:
A Pharmacy was contacted on 17th April 2014 in regard to the support required to enable us to support service users around their medication needs and to comply with HIQA Regulations.

As from week beginning 19th May 2014 the Pharmacist has agreed to carry out an initial audit of practice in regard to the receipt of medication. The Pharmacist will also provide feedback in regard to any changes required. He has also agreed to make himself available for the provision of telephone advice and also to talk to individuals in regard to their medication needs. Person Responsible: Care Team Coordinator

Proposed Timescale: 19/05/2014

Theme: Health and Development

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

There was no system in place for staff to check if residents who were self medicating were taking their tablets. Inspectors observed the practice of one resident who was storing her medication in egg cups left on the dining table.

Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
The care team coordinator to ensure that a risk assessment and assessment of capacity will be carried out for all residents currently self-medicating and ensure that support and encouragement will be provided to residents who wish to take responsibility for their own medication. Person Responsible: Care Team Coordinator.

Proposed Timescale: 31/08/2014

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 accurately describes the services provided in the centre but does not outline the circumstances in which a resident may be discharged from the service.

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) Admissions & Discharge Policy and Procedure to be developed.

b) The Service Manager will ensure the Policy is reflected in the Statement of Purpose.

Persons responsible: a) Service Quality Team, b) Service Manager

Proposed Timescale: 31/07/2014