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:	OSV-0003455
Centre county:	Wicklow
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
Lead inspector:	Julie Pryce
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
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 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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
12 June 2014 10:00	12 June 2014 21:00

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

Outcome 01: Residents Rights, Dignity and Consultation
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 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first monitoring inspection by the Health Information and Quality Authority (the Authority) of this designated centre operated by Cheshire Homes following the receipt by the Authority of unsolicited information relating to the management of complaints in the designated centre. The management of complaints and the investigation procedure were examined during the inspection and found to be satisfactory. As part of the inspection, the inspector visited the centre and met with residents and the staff members. The inspector observed practices and reviewed documentation such as personal plans, medical records and accident and incident records.

The designated centre comprises seven bungalows in a small street which accommodates nine residents. Each bungalow is self contained with a living area, kitchen bedroom and bathroom. There is also one bungalow which is the staff area and office from which the centre is operated.
Residents could call staff by using either manual or voice activated call bells.

Overall, the inspector found that residents received a good quality service. Healthcare needs were well managed and there was evidence of support for residents social care needs. However, improvements were required in some areas, for example in relation to health and safety and risk management. Non compliances are discussed in the body of the report and in the action plan.

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 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:
A complaints procedure was in place which was sufficient to guide staff and to guide anyone wishing to make a complaint. There was evidence of residents making complaints in keeping with this procedure, both verbally and in writing.

A complaints log was maintained, in which complaints, actions and complainants satisfaction with the outcome were recorded. Although not all responses to complaints were made in writing, a record of the response was documented in the log.

The inspector examined one outstanding complaint which had not been resolved and found that it had in the first place been escalated to the regional manager, then to the CEO, and that an external investigation was ongoing at the time of inspection. Written responses had been made to the instigators of the complaint who were aware that this investigation was ongoing.

This was the only aspect of this outcome to be included in this inspection.

Judgment:
Compliant

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 some evidence of individualised assessment and personal planning, but as the system was fairly new it was not in place for all residents. Where personal plans were in place they were based on assessment, written in consultation with the residents, implementation was recorded and review dates had been identified.

Some residents did not have a personal plan, but there was evidence that this was their own preference which was respected. Residents decided who had access to their personal plans.

Each resident had their own kitchen and did their own grocery shopping with as much or as little assistance as required. Care staff then provided assistance with the preparation of meals as required.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Whilst there were some structures in place in relation to safety and risk, improvements were required in several areas.

There was a risk management policy in place, but it did not fulfil the requirements of the Regulations, for example it did not consider the management of the risk of a resident going missing other than to refer to another policy. It did not provide guidance on the management of the risks of self harm, aggression and violence or accidental injury as required by the Regulations. There was also evidence of a Health and Safety statement being produced although it was not yet finalised.

Some risk assessments were in place, for example in relation to a resident smoking inside, but this was inconsistent, for example another resident who smoked had no risk assessment in place. There were no risk assessments in place regarding residents management of their own medication.

There was no risk register available on the day of the inspection but was reported by staff to be a book of risk assessments including a due date, and a system of escalation where risks could not be managed locally. The inspector was concerned as to how this risk register was informing practice given that it was not available to staff.

However, accident and incident reporting and recording was taking place and the form used included a section on the prevention of recurrence of the event.

Some fire training had been conducted and almost half of the staff had received this training. However, no fire drills had been conducted either with residents or with staff. The person in charge was required by the inspector to give an assurance that fire training would be provided as soon as feasible to all staff, and until this was in place there would be staff on duty at all times who had already received this training. This assurance was given and a written plan including acceptable completion dates was submitted to the inspector within the required time frame.

Fire equipment servicing and testing was up to date, apart from the individual smoke alarms in each accommodation. Staff reported that key workers checked these alarms regularly, but there was no record of this.

There was a personal evacuation plan in place for each resident, but there was no overall evacuation plan to guide staff in the event of an emergency.

Although work was ongoing on a health and safety statement it was not yet is place as discussed in Outcome 18.

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:
There were some systems in place to promote the safeguarding of residents and protect them from the risk of abuse. All staff on the day of the inspection were knowledgeable in the area of protection from abuse, however, not all staff had received training in this area.

Intimate care plans were in place for residents who required assistance in this area, however, the policy on the provision of intimate care required more detail in order to guide staff. For example, it made no mention of the residents preference in relation to the gender of the person assisting them with intimate care.

A call system was in place in each residents accommodation, this was either button or voice activated in accordance with needs, and allowed for a conversation between staff and resident. This communication channel was only opened when either instigated or accepted by the resident.

Residents were supported where necessary to manage their finances independently, and a policy was in place to guide practice.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

Findings:
The inspector found that residents healthcare needs were met, each resident had access to a general practitioner (GP), and to the services of allied health professionals such as Speech and Language Therapist (SALT), physiotherapist and public health nurses. There was evidence that the recommendations of these professionals was followed, and the implementation was documented in residents personal communication books. Residents also had access to external services and clinics where required.

Each resident had their own kitchen and did their own grocery shopping in accordance with their preferences, with as much or as little assistance as required. Care staff then provided assistance with the preparation of meals as required.

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:
The inspector found that while some policies and processes were in place for the management of medications, improvements were required. Residents were encouraged and assisted to manage their own medication where possible.

There was a policy on the safe administration of medications but this was not centre specific. For example, it referred to nursing staff and to the communal storage of medications, neither of which was the case in the centre.

There was a centre specific policy on self administration of medications, but there were no risk assessments in place for those residents who managed their own medications.

There was evidence of some recording of medication errors, but this was inconsistent. An error reviewed by the inspector had been rectified, but this had not been signed, recorded or reported. The inspector was concerned as to how learning from errors would take place if they were not consistently recorded.

Judgment:
Non Compliant - Moderate

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:
The inspector found that the person in charge of the centre was suitably qualified and experienced. He engaged in continuous professional development and was aware of his responsibilities under the regulations.

There were some clear management structures in place, for example the social care workers were supervised by the co-ordinators who reported to the person in charge who was the service manager.

Management meetings were held between the regional manager and the service manage several times a year, and the service manager met with the co-ordinators on a weekly basis, although these meetings were not documented. It was therefore unclear as to how any decisions made at these meetings were acted on.

However, staff meetings which were attended by the service manager were minuted, actions were documented and reviewed at each subsequent meeting.

However, whilst a shift leader was on duty each shift, there was no clear supervisory relationship between this person and other members of staff and there was not always a co-ordinator on duty. This is further discussed under Outcome 17.

Judgment:
Non Compliant - Minor

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 numbers and skill mix of the staff were appropriate to meet the needs of the residents. The times of staff rotas was managed to suit the individual routines of residents

Not all the documents required by the regulations were in place in relation to staff. One of the staff files examined by the inspector contained only one reference, certification for the declared qualification of one staff member was missing and garda clearance was not in place for one staff member.

Staff training records were maintained, but not all training was up to date as discussed under outcomes 7 and 8. There was no formal system of staff supervision or appraisal, and although a shift leader was on duty on each shift there was no clear reporting relationship between this person other staff members. It was therefore not clear that staff were appropriately supervised.

Judgment:
Non Compliant - Minor

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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Action Plan

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

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:	OSV-0003455
Date of Inspection:	12 June 2014
Date of response:	7 August 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not every resident had a personal plan.

Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

Please state the actions you have taken or are planning to take:
An assessment of social care needs will be carried out for each individual within the service by the care support staff (overseen and supported by the Service Manager) as appropriate and in accordance with individuals needs and wishes. A corresponding care plan will then be developed outlining each individual's interests, work, hobbies and social events.

Proposed Timescale: 19/09/2014

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:
The risk management policy did not include all the requirements of the regulations.

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 Irelands current Risk Management Policy has been reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (i).

Proposed Timescale: 30/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all local risks had been assessed.

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) Cheshire Irelands current Risk Management Policy has been reviewed and revised based on the requirements outlined in Regulation 26 (2).

b) A review of all risks will be carried out, and each individual will have any risk assessments required carried out by September 19th 2014 and placed in their files by September 27th 2014. An emergency plan will be developed for the service by September 30th 2014 and reviewed on a regular basis or as required.

Proposed Timescale: 30/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The recording and management of risk was not available in the centre.

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 risk register is now available within the service which consists of all risk assessments including a due date, and a system of escalation where risks could not be managed locally.

Proposed Timescale: 30/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No fire drills had been conducted.

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

Please state the actions you have taken or are planning to take:
Due to the nature of the service and the fact that individuals are living within their own homes, fire drills have never been carried out within the centre.

A system of regular fire drills (every 12 weeks) will commence on September 1st 2014. Records of these drills will be maintained within the service.

Proposed Timescale: 01/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had received 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 Training: June 23rd 2014. All staff identified have completed training.

Proposed Timescale: 23/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no record of testing of fire alarms.

Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
Due to the nature of the service and the fact that individuals are living within their own homes, regular testing of smoke alarms by care support staff has never been carried out within the centre.

A system of regular testing of smoke alarms (every 4 weeks) will commence on September 1st 2014. Records of these tests will be maintained within the service.

Proposed Timescale: 01/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evacuation plan.

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

Please state the actions you have taken or are planning to take:
An emergency plan will be developed for the service by September 15th 2014 (including an identified location to bring residents to in the event of an emergency). This plan will be reviewed on a regular basis or as required.

Proposed Timescale: 15/09/2014

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:
Not all staff had received training in the protection of vulnerable adults.

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:
All identified staff to receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Adult Protection Training: July 31st 2014, with 4 staff attending.

Proposed Timescale: 31/07/2014

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:
The policy on the management of medication was not centre specific.

Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
A review of the Cheshire Ireland policy on the safe administration of medications to be carried out by the Head of Clinical Support Services to ensure it is centre specific.

Proposed Timescale: 31/12/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no risk assessments in place for residents who managed their own medications.

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:
With the support of the Head of Clinical Support Services, the Service Manager to ensure that a risk assessment 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.

Proposed Timescale: 30/09/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all medication errors were recorded.

Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
The current Medication Management training programme has been reviewed by the Head of Clinical Support Services, further training and education have been developed and to be rolled out by December 2014.

A system of audit to be implemented commencing August 29th 2014 regarding medication errors to ensure all errors are recorded. Audits to be carried out weekly.

Proposed Timescale: 31/12/2014

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:** Actions from management meetings were not monitored. **Action Required:** Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. **Please state the actions you have taken or are planning to take:** Minutes from Management meetings held between the regional manager and the service manager, and the service manager and the co-ordinators will be documented. Actions required from previous meetings will be reviewed to ensure these are monitored, progressed and completed.
Proposed Timescale: 30/09/2014

Outcome 17: Workforce
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Not all the documentation in relation to staff as required in the Regulations were in place. **Action Required:** Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff. **Please state the actions you have taken or are planning to take:** A review of all staff files to be carried out by the Service Manager/Care Coordinator, utilising the regulations as a reference to ensure all documentation is present within the service.
Proposed Timescale: 30/09/2014
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** There was no clear structure of supervision of staff.

Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
A standardised performance management system is in the process of being rolled out nationally, the Eastern region is scheduled for roll out by 31st October.

Proposed Timescale: 31/10/2014