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<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland</th>
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<tr>
<td>Provider Nominee:</td>
<td>Mark Blake-Knox</td>
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<tr>
<td>Lead inspector:</td>
<td>Leone Ewings</td>
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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 monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From:  To: 
26 August 2014 10:00  26 August 2014 18:00
27 August 2014 09:00  27 August 2014 17:00

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<tr>
<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 13: Statement of Purpose</td>
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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection
This was the first inspection of the centre, and was announced to the provider and person in charge on 18 August 2014. The inspector ascertained the views of residents and staff members, observed practices, and reviewed all relevant documentation during the two day inspection. The provider was not present at this inspection to determine overall fitness and governance arrangements. However, the person in charge demonstrated sufficient knowledge of the legislation and statutory responsibilities.

The person in charge informed the inspector that in order to facilitate the decongregation of the centre, at a later date links were in place with staff who were engaging with preliminary work, and assessments relating to finding appropriate homes for current residents with community links and resources.

The designated centre is a two storey purpose premises built in 1974 and accommodation is provided on the ground floor with 20 single rooms for 20 residents. Volunteer staff are accommodated on the first floor of the premises. The premises were spacious, hygienic and well maintained.

The centre provides facilities and services for a wide range of residents including people with sensory, physical and neuro-disability. The age range of residents being
accommodated is approximately from 33 to 73 years.

Throughout the inspection the person in charge who is also known as the service manager demonstrated her knowledge of the legislation and standards, and had a person centred approach and awareness of pertinent issues relevant to the designated centre. She reports to the regional manager who reports to the provider. She was supported by a service quality officer on the day of the inspection.

There was a written statement of purpose in place which overall accurately described the service provided in the centre and the manner in which care is provided, to reflect the diverse needs of residents. Some minor improvements were required to the statement of purpose. The inspector met with the person in charge and service quality officer and outlined the inspection process and methodology and provided feedback at the end of the inspection.

The inspector met all of the residents living at the centre. In the main, the residents were aware of the inspection process and this had been communicated by staff at the centre. Residents expressed their satisfaction in respect of living at the centre and were satisfied with the accommodation and the routine day to day operations of the centre. Some of the residents expressed a wish to live more independently in the community. A project had commenced to investigate and facilitate the residents wishes to move on to life in the wider community, in various settings.

The inspector saw that residents’ rights, dignity and consultation were upheld, and a good standard of communication maintained. Service provision and care practices was observed to be respectful and appropriate, and maintained each residents privacy and dignity.

There is a draft admissions and discharge policy and procedure. There was evidence that residents were supported on an individual basis to achieve and enjoy the best possible health as residents had access to the general practitioner (GP) and allied health professional services. However, the inspector noted that each resident had not been fully protected by the centre’s policies and procedures in respect of medication management, and healthcare practices could be improved and become more evidence based.

The inspector saw that person centred care was promoted and there was evidence of opportunities for residents to participate in meaningful activities, appropriate to their interests and capacities.

From an examination of the day time staff duty rota, communication with and observation of residents and staff the inspector found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents. Staff demonstrated good knowledge of the residents and their needs and emphasised the importance of promoting a social model of care which embraced the concept of encouraging each resident to exercise choice and control over their lives in accordance with their preferences and maximising their independence. However, improvements were required with residents' personal plans and written healthcare plans and ongoing assessments of needs.
Non-compliances in six of the seven outcomes inspected against required improvement are identified in the action plan at the end of the report, in order to ensure compliance with Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities.
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 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:
The inspector was satisfied that in practice the individual supports provided to the residents were appropriate to meet their assessed needs. Overall it was judged residents' wellbeing and welfare was being maintained to a good standard. The feedback from residents was very positive and many residents expressed satisfaction with the environment, activities, food and staff availability. External activities and transport arrangements to facilitate this were found to be in place from the centre. A number of residents were wheelchair users and independence was promoted with the use of powered devices, assistive chairs and communication techniques. Improvements were required with documenting personal plans and involving residents in this process as each resident did not have a detailed personal plan in place, that reflects his/her needs, interests and preferences. The documentation reviewed primarily related to physical and health care needs and also involved the wider multi-disciplinary team, as outlined in Outcome 11.

The inspector reviewed two resident files and found that they had a comprehensive assessment completed on admission. Goals primarily related to healthcare delivery and were not focused on personal goals. The inspector confirmed with a number of residents that they were actively involved in day-to-day care choices. For example, residents spoke to the inspector about a long term goal of living in a community setting nearer their family. All of this information was not outlined in an outcome based personal plan which fully reflected the residents needs, interests and preferences. A record of how staff could assist the resident to maximise their opportunities to participate in meaningful activities was not evidenced fully. The person in charge spoke with the inspector and she acknowledged that work was required relating to documentation of
care and the use of personal plans. The inspector did not see any written evidence that each resident was involved in the development of their personal plan for 2014; records were not in place to reflect personal based goals achieved or reviewed to date for each resident in an accessible format.

Improvements were required with regard to the use of personal plans, goal setting and evidencing involvement of each resident in formulating a personal plan.

**Judgment:**
Non Compliant - Moderate

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**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:**
Overall satisfactory arrangements were in place to manage risk with appropriate risk management practices to promote and protect residents, visitors and staff. A review of the emergency plan in place was required.

The inspector read the Health and Safety statement which was found to be up to date. Individual personal evacuation plans were in place, and all staff spoken with were confident in their ability to evacuate the centre should the need arise. Staff spoken to by the inspector felt that they had been provided with clear guidance on what to do in relation to any fire safety procedures and evacuation. All staff had been provided with fire safety training, with some staff having completed additional fire warden training. Two staff members were on duty at night time, and additional volunteers lived on the first floor accommodation.

The inspector viewed records that fire equipment was serviced regularly, as were fire alarms and emergency lighting. Fire evacuation notices were posted clearly at each exit. Means of escape were kept clear and the inspector observed a staff member checking the fire doors on each corridor and completing the daily safety checks. The training records confirmed that staff had attended fire safety, fire warden, and fire drills at the centre.

The inspector reviewed the risk management policy dated 13 June 2014, which provides the framework where risk was managed and found this was adequate. Risk assessments of the environment and work practices had been undertaken in the centre. Overall these had been reviewed by the person in charge and the risk management/health and safety co-ordinator in the organisation to mitigate and manage risks. Individual assessments...
had been carried out for each resident to ensure that any risks were identified and proportionately managed. The inspector reviewed a number of these which were being updated regularly with the support of a multi-disciplinary team reflecting ongoing change.

For example, each resident had a personal moving and handling plan which provided clear guidance to staff on individual support needs in the area of manual handling. Two of the 20 rooms had in place ceiling track hoists to facilitate moving and handling requirements for residents. Three portable hydraulic hoists were also available for use throughout the building. Staff had completed moving and handling training every two years, and a staff member was a qualified instructor in this area.

Accidents, incidents and near misses were being recorded in detail and a copy of the reports were submitted to and reviewed by the provider. Incidents were being discussed at management meetings with a view to learning from adverse events and reducing the risk of recurrence. For example, an incident relating to moving and handling had been reported, and fully investigated and recommendations had been made and implemented.

Staff were fully aware of immediate fire safety procedures within the building. Staff were not fully aware of the contents of the written emergency plan, available to guide staff in the event of such emergencies as fire, power outages or flooding. The emergency plan did not contain any details of where the residents would evacuate to, should the need arise. The person in charge discussed this matter with the inspector during the inspection and agreed to action this and raise awareness of the contents of the existing emergency plan with the all staff, and review evacuation arrangements and inform staff accordingly.

Judgment:
Non Compliant - Moderate

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:
Residents spoke very positively about their living environment, and were very complimentary of all staff. Residents told the inspector they felt safe and enjoyed the privacy of having their own rooms. Many residents had lived at the centre for a large number of years and referred to individual staff members they would speak to if they had concerns.

Arrangements were in place to safeguard residents and protect them from all forms of abuse. The inspector observed staff interacting with residents in a highly respectful and friendly manner. Staff who spoke with the inspector were knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse, and had been provided with training in adult protection in the last two years. The adult protection policy dated May 2014 reviewed by the inspector gave guidance regarding responding to reports or allegations of abuse. Staff were knowledgeable about what action to take and reporting structures should they need to respond to any reports or incidents.

Staff also spoke to the inspector about residents they supported at the centre, and this was evidenced in the fact that a number of staff had been working with the residents for a number of years. The culture of the service was resident centred and staff frequently referenced residents rights; the right of a resident to refuse treatments and/or make their own choices.

There were intimate care plans in place to promote self-care and protection for residents who were receiving a high level of support in the area of personal care from male and female staff members. Individual preferences were documented and found to be respected.

The centre operated a restraint free environment and the policy dated 1 May 2013 was specific on the use of any form of restraint (or an enabler), and how a risk assessment would be completed. The environment was not found to be restrictive in any way, with wide corridors and access to the garden and front door and nearby transport parking. The environment and equipment was found to be accessible particularly for residents who were wheelchair users.

An example of a risk assessment for bed rails was shown to the inspector to guide and inform staff. However, not all enablers in use were fully documented in line with the revised policy or as part of an overall care plan in place for each resident and improvements in documentation were required in this area as outlined in Outcome 18.

The inspector did not review financial management at the time of this inspection as this will be inspected against at the time of the next registration inspection.

**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:
The inspector found that overall residents were fully supported to access health care services relative to their needs. Generally, residents’ health care needs were met on a daily basis with each staff member having an in depth knowledge of each residents needs. Daily handover meetings discussed and reflected on care practices and were observed by the inspector. However, there were significant deficiencies in documentation meaning that not all care delivery was fully evidence based or linked to an individuals' personal plan. For example, pressure ulcer management and gastrostomy care. The inspectors' review of records confirmed that not all the clinical needs identified had a corresponding written care plan in place to address the identified needs.

The inspector reviewed the healthcare plans and assessments and found that they had access to a general practitioner and timely referrals were made by staff and the GP. There was evidence that residents accessed health professionals such as chiropodists, dietician, speech and language, dental, psychiatry, psychology, tissue viability and other multi-disciplinary supports.

Residents had access to nursing staff during some day shifts, and the person in charge also has a nursing qualification. There were individual health care plans in place for specific needs such as in the area of mobility, skin care and catheter care. The inspector was notified that one resident with a pressure ulcer was receiving care at the centre. However, further to information reviewed on inspection two further residents were identified during the handover as having compromised tissue viability and skin problems. The practices and equipment in place were found to be adequate, and the use of a wound chart evidenced improvements. Referrals to tissue viability had taken place and treatments fully implemented. Records and care planning relating to pressure ulcer prevention and management required improvement.

From reviewing residents files the inspector determined that detailed robust care plans were not in place to address all their identified healthcare needs. Improvements were required with regard to documentation and care planning of actual care. For example, a care plan reviewed for care of a gastrostomy tube was not fully reflective of actual practices or fully evidence based and required review. Staff discussed with the inspector the use of heated water for flushing a gastrostomy tube, which was not in line with the centres written policy reviewed by the inspector. The inspector had a detailed discussion with the person in charge who undertook to review the practices and source relevant
training and update all relevant staff.

Residents informed the catering staff of dietary and menu requirements. Residents’ dietary and nutritional needs, as well as food preferences were also detailed in their individual assessments. The inspector observed that residents were provided with a choice of meals and residents could have snacks at any time. The provision of meals for residents was in the dining area or individual rooms as appropriate to preference. Appropriate tables and table settings were in place to facilitate independent dining. Those who required assistance with mealtimes had individual staff assist in a sensitive and appropriate manner. Food quality and choices were available, and service provision was good. Mealtimes were observed as unhurried, and the inspector observed breakfast and lunch time. Residents who required food fortification or supplements had these provided and staff monitored resident weights and screened for malnutrition. Some residents had fridges and kettles in their own rooms and liked to have this independence with their own snacks and drinks.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Overall it was judged that each resident was protected by the centre's policies and procedures for medication management. The inspector found that medication management policies and practices were largely in line with best practice and legislative requirements. The inspector formed the view that the standard of oversight and documentation of medication management was of an adequate standard. However, some improvements were required with regard to prescribing, administration and supports available from pharmacy provider.

All residents were supported in the administration of medication by either a nurse or a senior care support worker with a documented medication management competency assessment completed. The receipt of medication was being recorded and medication was being stored in locked trolleys in the care office. The General Practitioner (GP) had prescribed all medication on the prescription sheet in use. The prescription sheet provided clear guidance to staff on the dose and times that medication should be administered, and clearly documented allergies and individual requirements. However,
the route of administration for all prescribed medication was not clearly stated on the prescription chart. For example, via gastrostomy or catheter tubing. Medication management training records were up to date and evidenced all staff involved with administering medication were up to date with training. Staff demonstrated competency in administration practices observed by the inspector.

Following a review of medication management the inspector determined that some improvements were required to the current prescription sheet in use; the practices relating to prescribing and administering of crushed medication, and the use of catheter care washouts. The provider had reviewed a draft policy on medication management, and the inspector was informed that this was about to be implemented at the time of the inspection. Further to discussion with the person in charge the inspector requested that feedback from this inspection be considered prior to implementation of the revised policy. The community pharmacist had visited the centre to complete an audit, and these records were available and read by the inspector. The pharmacist was not substantially involved in reviewing medication as part of the multi-disciplinary team, but was available for consults if required by staff or if a resident had a query. Some prescribed medications were found to have been routinely crushed for administration purposes, and there was no evidence that this had been substantially reviewed by the pharmacist for safety and suitability of this method of administration.

Daily medication checks took place on the night shift, and any drug errors or omissions, recorded as a clinical incident. These incidents were being carefully monitored for improvement, to mitigate risk, and for action by the person in charge within the risk management policy and procedures.

Judgment:
Non Compliant - Moderate

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 copy of the current statement of purpose was requested by the inspector prior to the inspection. Overall, the statement of purpose sets out the facilities and services provided to residents and sets out the aims, objectives, and ethos of the centre. However, a number of improvements and clarifications were necessary to fully meet Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated
Centres for Persons (Children and Adults) With Disabilities) Regulations 2013.

The follow clarifications and improvements were required;
- number of residents the centre is designed to accommodate
- actual whole time equivalent for nursing and care staff
- organisational structures.

**Judgment:**
Non Compliant - Minor

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**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 provider had ensured that there were robust recruitment processes in place and staff employed at the centre were suitable to work with adults with disabilities. However, it was judged that there were not sufficient nursing staff on duty to meet the assessed needs of residents relating to the identified nursing care and supervision needs identified on health care plans. The inspector determined that the staffing skill mix available to meet resident needs required some review, based on the findings of this inspection, and review of staffing rosters. For example, the requirement to monitor progress of pressure ulcers, supervision of gastrostomy feeding, and the need to commence robust personal plans for each resident.

The inspector examined copies of planned rosters for the centre and found that overall staffing levels were adequate to meet the day-to-day needs of residents on the day of the inspection. The person in charge was in a full-time position managing this centre approximately five days per week. She managed all staff working at the centre, including catering, laundry, maintenance and nursing and social care staff. The rosters were well maintained and clearly indicated the staff numbers and shifts worked. One part-time staff nurse was employed, with a further vacancy for a part time staff nurse, which was covered by an agency nurse while the recruitment process was in progress.

A registered nurse was not found to be on duty every day on the roster and averaged approximately six hour shifts or no nursing cover provided on some dates. This was not consistent with the statement of purpose and function as outlined in Outcome 13. Two
social care staff covered the night time shift, with some staff staying till late in the evening to facilitate resident activity and lifestyle choices.

The inspector held a discussion with the person in charge and related concerns with regard to the deficits in provision of nursing and healthcare needs as outlined in Outcome 11 of this report. In addition the responsibilities relating to medication management remain with the service manager who is also the person in charge within the scope of the medication management policy. Evidence under Outcome 12: Healthcare needs demonstrates the improvements required in healthcare plans and supervision of care delivery on a day-to-day basis.

Staffing rosters were found to be generally flexible to the changing needs of each resident. The shift lead on each shift supervised social care staff, and care delivery. Nursing staff and senior care support workers trained in medication management undertook responsibilities for medication administration at the centre. The handover observed at 2pm was comprehensive, interactive and informative to staff coming on duty. The inspector held a discussion with the person in charge and was informed that a recruitment process was ongoing for an additional part time staff nurse. A comprehensive review of staffing was not available and was based on day to day needs and planning in the short term. The inspector found staff had a comprehensive knowledge of the residents’ likes, dislikes and life histories and staff throughout the inspection were helpful and knowledgeable. Arrangements were in place to manage planned and unplanned staff leave and there was evidence of staff participating in staff meetings. The sample of staff files reviewed were in compliance with legislative requirements of Schedule 1.

Review of documentation in relation to training and discussions with staff confirmed that staff working in the designated centre had participated in mandatory training for example fire safety, moving and handling, medication management, first aid, adult protection, infection prevention and control and complaints management. Comprehensive records of training and discussion with staff confirmed training needs were being met.

A volunteer policy was in place which included Garda vetting requirements and supervision arrangements.

**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:**

Leone Ewings  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider's response to inspection report

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<td>26 August 2014</td>
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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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All residents did not have a comprehensive personal plan which reflected the involvement of the resident and personal goal setting.

Action Required:
Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident’s wishes, age and the nature of his or her disability.

**Please state the actions you have taken or are planning to take:**
All residents will undergo a comprehensive needs assessment by the nursing team and trained care staff.
Training will be provided to care staff in the assessment and development of social care plans by the clinical support service team. Training in assessment will be provided the staff team in on the following dates to
- 9 staff will be planned on January 20th 2015
- 10 staff will be trained on March 11th 2015
- 10 staff will be trained on May 14th 2015

A Personal Plan will be completed for each resident by 31st May 2015.
The individual needs assessment will inform the development of each resident Personal Plan. The service nurse & manager with the support of the Clinical Services Support Team will supervise the assigned care staff to develop each individual Personal Plan

As each staff group is trained they will be assigned one resident to work with and will be given a deadline for completion of the personal goals aspect of the residents plan. Residents who will require the greatest support will be prioritised and planning will commence immediately following training. Therefore
- 9 residents will have a personal plan addressing their personal goals completed by 28th of February 2015
- 10 residents will have personal plans addressing their personal goals completed by 30th of April 2015

This plan will be presented in an accessible format as appropriate and reviewed on an annual basis or as required.

**Proposed Timescale:** 31st May 2015. Responsible Individual(s): Service Manager, Service Nurse & Clinical Services Support Team

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All residents did not all have access to their personal plan in an accessible format.

**Action Required:**
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

**Please state the actions you have taken or are planning to take:**
The Personal Plan which includes both the social care aspects and the health care interventions will be discussed and agreed individually with each resident by 31st May 2015. Where required, easy read and appropriate alternative formats will be utilised to
record these plans and to agree and share changes and update on an ongoing basis with each resident.

**Proposed Timescale:** 31st May 2015. Responsible Individual(s): Service Manager & Nurse

### 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 emergency plan was not specific regarding any arrangements to evacuate residents to a designated location.

**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:**
The emergency plan will be reviewed to define a designated location for evacuation by 15th December 2014.
The centre has a verbal agreement with a near by designated centre for the purpose of evacuation in an emergency. The Hospital manager has been requested to confirm this arrangement formally in writing. On receipt of this Cara Cheshire Home’s emergency plan will be amended to reflect this.
This plan will be reviewed on an annual basis or as required.

**Proposed Timescale:** 15th December 2014. Responsible Individual(s): Service Manager, Risk Management / Health & Safety Co-ordinator

### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Detailed evidence based written healthcare plans were not found to be in place for healthcare needs, to inform and guide staff and in line with policies on pressure ulcer management and gastrostomy care.

**Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident’s personal plan.

**Please state the actions you have taken or are planning to take:**
The Clinical Support Service Team will provide in service training to the care staff in the application of best practice guidelines in the areas of pressure ulcer management and prevention and gastrostomy care(in line with organisation policies and procedures) by
31st December 2014.

- In service training in will be provided by the Clinical Services Support Team to the staff team in Pressure Ulcer Management and Prevention on 17th December 2014.
- In service training will be provided by the Clinical Services Support Team to the staff team in gastrostomy care on 17th of December 2014.
- In the event that a staff cannot attend this training it will be offered again on 20th January 2015

In tandem with the development of personal plans, care staff will be trained and supervised in the development of health care plans for the management of pressure ulcer management and gastrostomy care by 31st May 2015.

- 9 Staff will be trained in health care assessment and care planning on December 8th
- Each of these staff will be assigned one resident to assess and develop the associated health care plan for.
- Residents with high healthcare and social support needs will be prioritised.
- In this way all resident who require health care plans for pressure ulcer management and gastrostomy care will have these completed and in place by 20th of January.
- A further 10 staff will be trained in health care assessment and care planning on the 11th of March 2015
- Each of these staff will be assigned one resident to assess and develop the associated health care plan for.
- All residents will now have an assigned staff to work with them and their healthcare plans will be completed by 31st of May.
- And the remaining staff will be trained in health care assessment and care planning on 14th May 2015

The development of these plans will be informed by the outcomes of each resident’s comprehensive needs assessment by the nursing team and trained care staff. This plan will be presented in an accessible format as appropriate and reviewed on an annual basis or as required.

Proposed Timescale: 31st May 2015. Responsible Individual(s): Service Manager, Nursing staff, Cheshire Irelands Clinical Services Support Team

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 prescription sheet did not contain the route of administration and medication was not individually prescribed as crushed.

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:**
Service Nurse will facilitate a full review of all residents Prescription Sheets by their GP and all information required for the safe administration of medication will be included by 10th November 2014

**Proposed Timescale:** 10th November 2014 - completed

**Responsible Individual(s):** Service Nurse & GP

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medication had not been reviewed by a pharmacist to ascertain suitability for crushing prior to administration.

**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:**
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:
Service Nurse will facilitate a full review of all residents Prescription Sheets by their GP and all information required for the safe administration of medication will be included by 10th November 2014

Service Manager will review the support available from the current pharmacy and seek greater support and regular site visits to include an audit of records. In the event that the current service provided cannot accommodate this support requirement, the Service Manager will source an alternative pharmacy by February 28th 2015.

The Clinical Services Support Team will train care and management staff in the revised CI Medication Management Systems Audit by 31st January 2015. The full audit program will be operated in the service every six months with a program of random audits of administration and records occurring every three months.

Bi annual audit results will be collated by the service and returned to the regional Clinical Education Facilitator for analysis and results will be returned to the service and will be collated nationally.

Quarterly random audits will be analysed by the Service Manager and Nurse and results will be returned to the Clinical Services Supports Team.

**Proposed Timescale:** 10th November 2014 – completed /31st January 2015/ 28th
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 in not fully in line with Schedule 1, and requires review to reflect actual staff at the centre, organisational structure and maximum number of residents accommodated.

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:
Service Manager will review statement of purpose to ensure it accurately reflects staff at the centre, organisational structure and number of residents accommodated by 30th November.

Proposed Timescale: 30th November 2014 - completed
Responsible Individual(s): Service Manager

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The skill mix of staff available to meet the changing needs and supervise appropriately was not adequate at all times particularly relating to the availability of nursing staff with the appropriate skills knowledge and experience.

Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
A review of the service roster and skill mix based on the assessed needs of the Residents has been completed in the last six months.
The Service Manager is actively recruiting a WTE CNMI to expand the availability of nursing support to the service. The advertisement of this post has been placed and closing date for applicants is December 8th 2014.
Review of the staff roster in quarter 3 of 2014 identified that staffing ratios were too high in the afternoon and evening and to low in the mornings. The Service Manager has
opened discussions with the union representing the staff team to review these findings and agree changes to the shift pattern of existing staff. It is proposed that these changes will be implemented by 31st March 2015.

Clinical Services Support Team will commence the roll out of a standard clinical audit program across medication management systems, restraint managements and personal planning in the service by 31st November 2015.
- The existing Medication Policy audit will be replaced by an expanded Medication Management Systems audit in quarter 1 of 2015.
- A newly designed audit of the CI Restraint Policy will be introduced in quarter 1 of 2015.
- Personal planning audit will be introduced in quarter 3 of 2015.
- Audit process will be carried out quarterly as standard.

Results will be returned to the Regional Clinical Education Facilitator for analysis and outcomes will be returned to the service and monitored nationally. As a result of these audits, identified supports and interventions will be provided by both internal and external supports as required.

**Proposed Timescale:** 31st March 2015 /31st November 2015  
**Responsible Individual(s):** Regional Manager / Service Manager / Cheshire Irelands Clinical Support Team / Cheshire Irelands Human Resources Department.

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Nursing care relating to pressure ulcer prevention and management; catheter management and gastrostomy care, was not always provided on a daily basis or fully documented in an evidence based manner.

**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:**
- The Service Manager is actively recruiting a CNM I to address an identified need for expended nursing cover.
- This post will work a roster of 5 over 7 and will be in addition to the existing 11 staff nurse grade hours within the service.
- The Clinical Support Service Team will provide in-service training to the care staff in the application of best practice guidelines in the areas of pressure ulcer management on 17th December 2014.
- The Clinical Support Service Team will provide in-service training to the care staff in the application of best practice guidelines in gastrostomy care on 17th December 2014.

As part of this training input and as part of the training in the development of Personal Plans, care staff will receive further training in recording and detailing the daily and
ongoing management of care on December 8th 2014, 17th, January 20th 2015, March 11th 2015 & May 14th 2015. Care staff will receive in service training from the Clinical Services Support team in pressure ulcer management and prevention & gastrostomy care on 17th December 2014 and 20th January 2015.

The introduction of a Personal Planning audit in 2015 will allow the ongoing monitoring of care records.

**Proposed Timescale:** 31st May 2015  
Responsible Individual(s): Service Manager / Nursing staff / Cheshire Irelands Clinical Services Support Team / Learning & Development Manager.

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
No evidence of up to date gastrostomy or pressure ulcer management training for nursing staff working at the designated centre.

**Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**
Continuing Professional Development and further training opportunities will be provided to Nursing Staff & Care Support Workers to ensure they have the knowledge and skills to provide the high quality evidence based interventions in the areas of pressure ulcer prevention and management, and gastrostomy and catheter care and management by the April 30th 2015. Training opportunities will be ongoing within the service throughout 2015.

Existing nursing staff will be required to attend an accredited continual professional development course in Pressure ulcer prevention and management, gastrostomy care, and catheter care by 31 March 2015.

**Proposed Timescale:** April 30th 2015  
Responsible Individual(s): Service Manager/ Cheshire Ireland’s Learning and Development Manager/ Cheshire Irelands Clinical Support Team